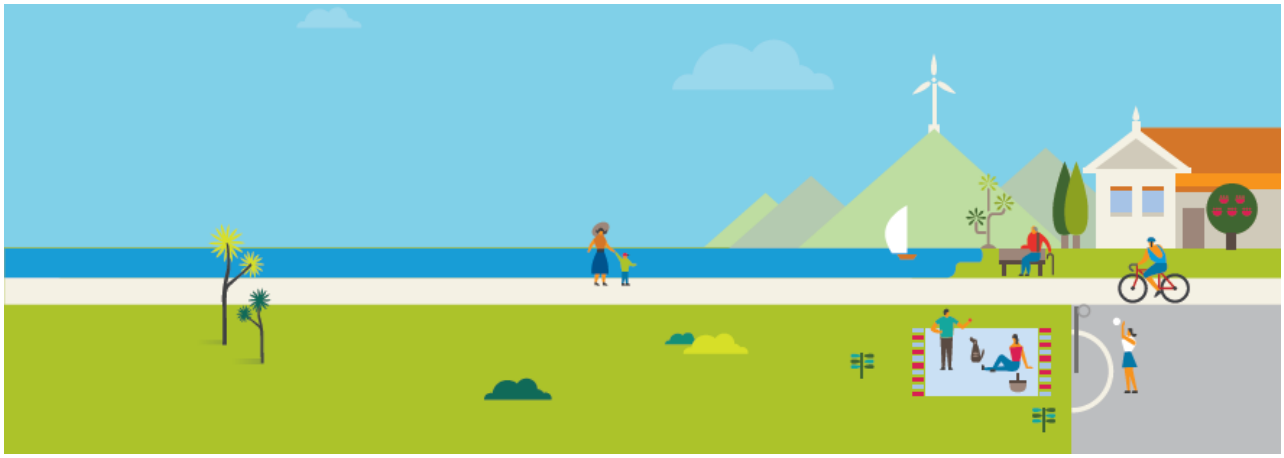
Living my Life Service
Operational Guidelines

Version: May 2022

Enabling self determination about:

Where I live,
what I do,
where I go and
who with

Ka whakamanaia te rangatiratanga o te tangata mō ēnei āhuatanga e whai ake nei: "Te wāhi e noho ana au, ka aha au, ngā wāhi ka haerea e au, ki a wai hoki"



This is a living document and will be updated as required

Useful contacts and telephone numbers

Delivering Living my Life on ACC's behalf is likely to involve you contacting a number of our teams. Here are their contact details.

ACC Provider Helpline	Ph: 0800 222 070	Email: Providerhelp@acc.co.nz
ACC Client/Patient Helpline	Ph: 0800 101 996	
Provider registration	Ph: 04 560 5211	Email: registrations@acc.co.nz
	Fax: 04 560 5213	Post: ACC, PO Box 30 823, Lower Hutt 5040
ACC eBusiness	Ph: 0800 222 994, option 1	Email: ebusinessinfo@acc.co.nz
Health Procurement	If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team: Email: health.procurement@acc.co.nz Ph: 0800 400 503	
Engagement and Performance managers	Engagement and Performance managers can help you to provide the services outlined in your contract. Contact the Provider Helpline or https://www.acc.co.nz/for-providers/provide-services/provider-relationship-team/#find-an-engagement-and-performance-manager for details of the engagement and performance manager in your region.	
ACC Portfolio	Contact the Provider Helpline for details of the Portfolio Advisor or Manager for Living my Life Service.	

The ACC website can provide you with a lot of information, especially our “for providers” section. Please visit www.acc.co.nz

Contents

How to read this guide

Read these operational guidelines with the:

- Standard Terms and Conditions document; and
- Living my Life Service Schedule ('your contract').

The services delivered must reflect the expectations outlined in the Living my Life service specification (contract). Where there are any inconsistencies between this operational guideline and the contract, the contract will take precedence.

ACC will work collaboratively with suppliers to improve the operation of the service and we will ensure this document is up to date with any service improvements we have made.

ACC will tell you when a new version is available on the ACC website at www.acc.co.nz.

Definitions of the Parties

ACC Recovery team member	Is a staff member either from - Assisted Recovery - Supported Recovery - Partnered Recovery
Client	The client is the person with the covered injury.
Family / Whānau	These are the people with a close personal relationship with the client.
Supplier	The entity holding a contract with ACC to delivery Living My Life services. They are responsible for all the services delivered and all actions taken. Where a supplier has contracted another team to provide services, this team is not subcontracted. The contracted supplier is fully responsible for all the service delivery as they cannot be transferred to another supplier.
Provider	An individual working for the supplier either as an employee or contracted.

1. Introduction

The Living my Life service (Service) is a disability support service delivered by a multidisciplinary team in the community to ACC clients who have a long-term disability because of an injury.

This document is for the suppliers and providers delivering the Service. It outlines the service expectations of the Living my Life service and the underpinning Service philosophy.

2. Purpose

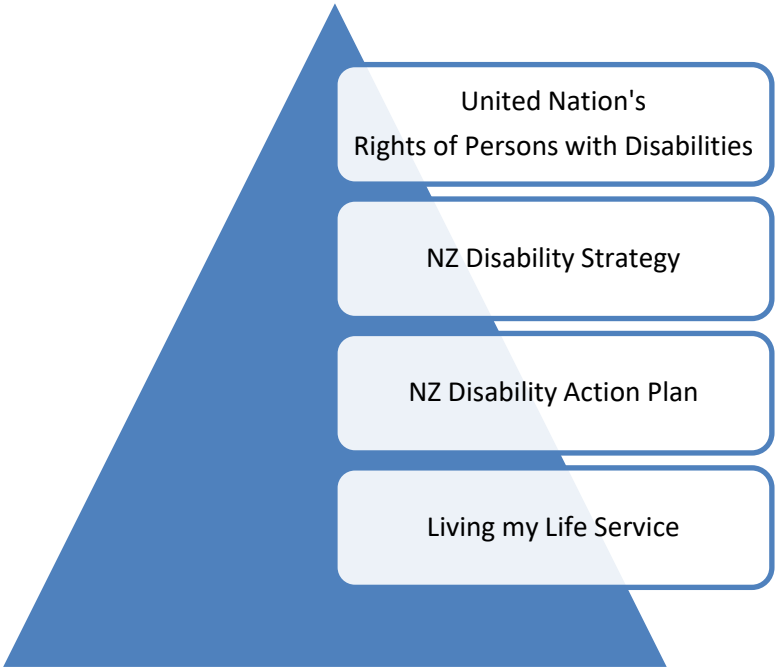
The Service provides individualised disability support with the goals of:

- Reducing the client's barriers to participation
- Increasing the client's independence, meaningful engagement and participation in the local community
- Increasing the client's achievement of personal, community and employment goals to engage in life roles.

- Supporting the client's decision-making by increasing their choice and control about:
    - natural supports
    - mainstream and universal supports
    - funded services
    - disability support
    - self-management of services, support and funding.
- Increasing the client's ability to live an everyday life.

3. Philosophy

The Service aligns with the international and national strategic direction.



The provision and delivery of Living my Life incorporates contemporary disability practice internationally and nationally; - NZ Disability Strategy and NZ disability sector transformation - Self-determination of "where I live, what I do, where I go & who with".	To obtain a copy of the two documents mentioned please see email Carol Krishnan, portfolio advisor. Carol.krishnan@acc.co.nz

3.1. Living my Life Service principles

The following principles reflect ACC commitment to supporting clients to gain and maintain a greater level of participation.

(a) **Person-directed -** *E Anga ana ki te Tangata*

The person has choice and control about supports and providers needed to facilitate participation in their chosen roles and activities

(b) **Whole of life -** *Te Oranga Katoa*

The person's supports are tailored to encompass the changes in roles and experiences that take place across a person's life journey

(c) **Connectivity** - *Ngā Tūhononga*

The person's supports focus on engagement and the supports are provided in the communities that are meaningful to the person and their family/whānau

(d) **Embracing diversity -** *Te whakanui i te matahuhuatanga o te tangata*

The person's supports are tailored to recognise and respect their own identity and diverse values and the values of their family/whānau and community

(e) **Citizenship -** *Te manaporitanga*

The person has self-determination that supports their full participation, inclusion and leadership in life, as a citizen.

3.2. Disability Support philosophy

Person-directed

Each person who has a significant impairment or disability will experience unique impacts on how they live their lives. ACC and providers will minimise systemic barriers to the client being able to exercise choice and control of their services, support and funding. Being person-directed ensures ACC is investing in building client capability to have **choice and control** and sector capacity to enable **client capability**.

Outcomes focussed

The Living my Life services are provided by suppliers experienced in understanding the lived experience of people with disabilities and their family/whānau. The suppliers will work with the client and their family/whānau to achieve outcomes that are **meaningful** to them.
Being outcomes focussed ensures the right mix of support to **improve skills and capability** towards full participation and inclusion and reduce over-reliance on formal support.

Empowers engagement and participation

The client, their family/whānau will work in partnership with ACC and their chosen provider to create innovative solutions to achieve participation outcomes. **Empowering participation** ensures clients build local, real and sustainable networks of support.

Minimises the impact of disability

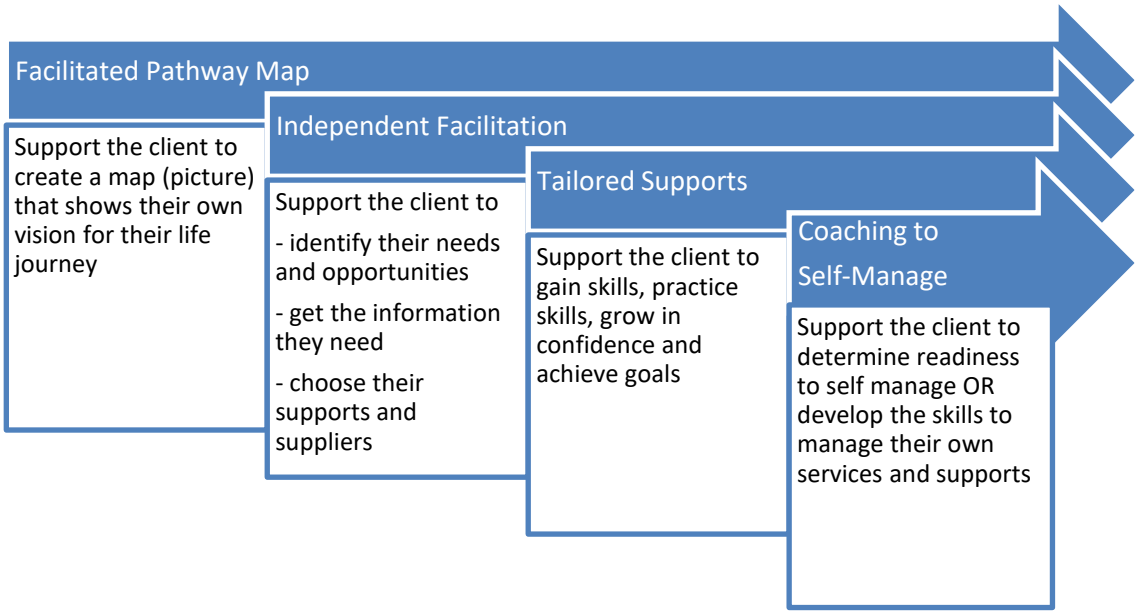
Providers work in partnership with local, cultural, community and employment networks to **enable social inclusion and citizenship**. Building local networks ensures people can live an everyday life.

3.3. Building service capability

ACC encourages suppliers to expand the support services they provide. As suppliers build capacity, relationships or partnerships, they may apply to deliver all Service components.

4. Services Description

The Living my Life service consists of four components of disability support, that are personalised to the individual client's aspirations and goals, in order to achieve participation outcomes. The four components are:



Each Service component focuses on building the client's capability and life skills to create community and employment opportunities and increases the client's ability to choose and direct the services and supports they receive.

Facilitated Pathway Map (FPM) *How do I want my life to be?*	A short-term support intervention for clients who would benefit from a co-design approach to create a visual map; by exploring what is important to them, their aspirations and life journey. This can be repeated when the client has an identified need for the service component.
Independent Facilitation (IP) *What are my service options?*	A short-term support intervention for clients who would benefit from use of a supported decision-making approach to create a vision of what support they need, how to access information and how to choose their supports and suppliers. This can be repeated when the client has an identified need for the service component.
Tailored Supports (TS) *I need help to get there*	A short, medium or long-term episode of delivery of disability support for clients who would benefit from a capability (strengths-based) approach to facilitate increased engagement and participation across all areas of their life, including employment, transitions into adulthood and activities.
Coaching to Self-Manage (CSM) *Can I manage my support services myself?*	A short-term support intervention for clients who would benefit from a supported decision-making approach to learn about Self-Management, determine their readiness to self-manage and choose the type of ongoing support they will require to manage their budget and direct their services and support. This can be

repeated when the client has an identified need for the service component.

5. Responsibilities

5.1. Supplier responsibilities

The supplier is responsible:

to…	for…

Client	• assigning a suitably qualified and experienced professional or disability support worker to work with the client, family and whānau to deliver the required components of the Service
	• ensuring that a meaningful goal setting approach or similar is used
	• focussing on the client's aspirations
	• facilitating and encouraging the client to aspire to new ways of doing what is important to them
	• ensuring client has every opportunity to investigate the available natural, funded supports, cultural and community resources
	• delivering activities/programmes one to one or in group settings to achieve goals
	• ensuring all the materials, equipment and facilities (at provider base and/or in the community) required are available for the delivery of support and activities and safe for clients to attend
	• maintaining good working relationships with other service/support suppliers and mainstream/universal community organisations
	• facilitating the client's understanding of and access to Self-Management
	• ensuring the client is supported to make decisions and exercise choice and control about the support they receive
	• providing a copy of the pathway map, summary or support plan, as relevant
	• for considering any barriers (and developing mitigation strategies to address these) such as (and notifying ACC):
	  ○ their travel to and from activities
	  ○ cost of community activities and what the client can reasonably afford
	  ○ environmental barriers such as access to buildings, disability parking
	  ○ communication platforms
	  ○ written or digital information
	• liaising with other community organisations to determine discounts and arrangements that can be utilised for the client

to…	for…
	• deliver support that is meaningful to the client, their family/whānau and respects their identity and diverse values • ensure the client choses which of their family/whānau and broader circle of support will play a key role in their disability support • alert the ACC recovery team member of any needs/issues/risks/vulnerabilities identified while working with the client • link with other service suppliers to ensure the continuity of the goals the client is working on. *Case conferences maybe considered* • keep the recovery team member up to date as per the communication plan.
ACC	• reviewing the referral promptly and accepting or declining the referral within specified timeframes • assigning a suitably qualified provider/team to deliver the components • nominate a person to have contact with ACC, on a case by case basis • working within the timelines • employing contemporary disability practice, which aligns to the Living my Life vision and principles • ensuring that the Meaning Map goal setting approach or similar is used to set and measure goal attainment for Tailored Supports • maintaining regular contact with the recovery team member (as agreed) • providing a copy of the Pathway Map, Summary or Support plan as relevant • advising ACC of any barriers a client may have for their travel to and from activities • inform ACC of any issues in the provision of the service via email, phone or Face to face • raise any issues service and suggest solutions to achieve the client outcomes • ensure appropriate representation by the provider team in service performance discussions • inform ACC promptly when any contact or situation details change • alert the ACC recovery team member of any needs/issues/risks/vulnerabilities identified while working with the client and their family/whanau.
Other service suppliers	• maintaining good collaborative working relationships • providing and receiving information appropriate to the situation and need.

5.3. ACC responsibilities

ACC is responsible:

to…	for…
Clients	• ensuring the client gets the appropriate services and support keeping the client and their family/whanau informed of progress towards their Individual Plan • making timely, efficient, and effective decisions

Suppliers	• participating in planning discussions when invited (case conference)
	• making prompt decisions based on the available information or, if the information is unavailable, investigating as appropriate
	• working collaboratively with the supplier
	• agreeing new timeframes where the client's needs cannot be meet within the existing timeframe
	• keeping them up to date regarding:
	  ○ any other assigned service suppliers
	  ○ any delays or issues that may impact on service provision
	  ○ any risks/vulnerabilities ACC knows of that the supplier needs to be aware of
	• following up with the supplier if they have not been in touch as agreed
	• seeking clarification from the supplier if progress and outcomes are not being achieved.

Other service suppliers	keeping them informed of any relevant information.

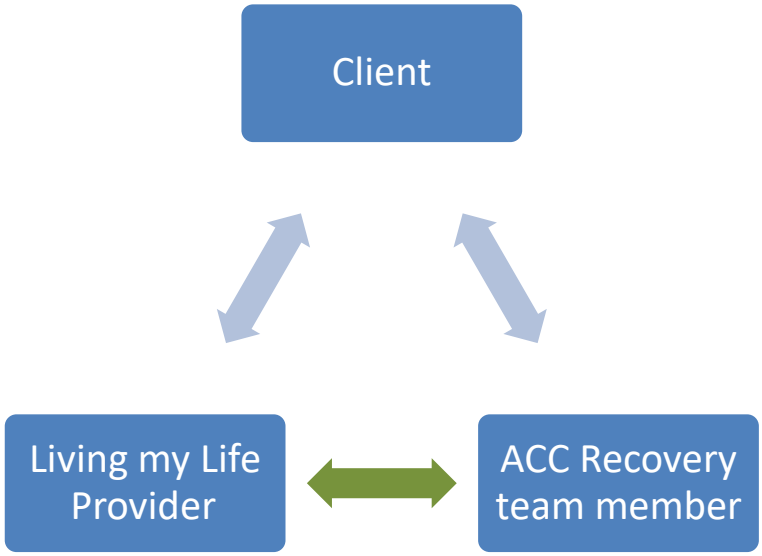
5.4. Client responsibilities

The client is responsible for:

- attending appointments or rescheduling them when they are unable to attend, with reasonable notice
- participating in the support service process
- their own travel from home and to the supplier and to community-based activities
- self-fund any activities they choose to engage in that have a cost associated with them
- discussing any problems that may impact on their participation with their recovery team member and supplier.

6. Communication and relationships

This service has a three-way relationship. The co-ordination of the communication can help or hinder the client's engagement and participation.



The partnership between the supplier and the recovery team member is one of the most important tools for ensuring the best outcomes for clients. The partnership supports the client to live the life they aspire.

To be effective this relationship needs to be based on:

- mutual respect
- open communication
- agreed timeliness and quality
- agreed client outcomes
- shared understanding of contemporary disability practice.

Communication includes:

- formal reporting,
- regular informal contact through email or phone calls

Communication is based on an agreed communication plan including:

- the client's current status
- the client's progress towards achieving their meaningful goals
- expression of interest by client to self-manage services and support
- changes in family support or living situation
- concerns that behaviours or living situation may indicate the client is vulnerable or at risk.

7. Client Eligibility

A client is considered eligible to Living my Life when the client's injury and its consequences impacts on their ability to participate and enjoy the normal activities of life.

The follow list describes some of those impacts.

- Facilitated Pathway Mapping (FPM)
- Independent Facilitation (IP)
- Tailored Support (TS)
- Coaching for Self-Management (CSM)

Client Eligibility Criteria *(Client should have one or more)*	FPM	IP	TS	CSM
Difficulty identifying their aspirations and goals	✓			
Difficulty adapting to their disability	✓	✓	✓	
Limited work experience, lack of confidence or self-belief that they can be employed either in paid or unpaid situations	✓	✓	✓	
A lack of social connections and or engagement in leisure, recreation, or other community activities	✓	✓	✓	
A change in a relationship, role and living situation that is impacting on their community or work life	✓		✓	
Limited capability managing transition milestones such as moving from school to adult life or work to retirement			✓	
Limited skills to be able to re-locate residence and/or live independently			✓	
Limited knowledge or awareness of support or universal options in their community		✓		
Lack of connection to their cultural networks and the local community	✓		✓	
Poor problem-solving and decision-making skills	✓	✓	✓	
Behavioural or cognitive needs impacting on client or public safety			✓	
At risk of isolation or living in vulnerable situations			✓	
High and complex physical and/or social needs			✓	
Limited knowledge of how Self-Management works or has never considered Self -Management for themselves.				✓

The recovery team member will help the client and their family/whānau decide which LML service component best meets the client's needs at the moment, by reviewing the client's current assessments and services while keeping in mind the client's age, injury and stage of life. ACC takes a wide range of information into account

- Social Rehabilitation Needs Assessment
- Support Needs Assessment
- Training for Independence report recommendation
- Residential Rehabilitation supplier recommendation
- Case owner's assessment

8. Service Delivery

8.1. Service Component Matrix

This matrix shows what a supplier is expected to complete in each service component based on the key philosophies from UNCRPD, NZ Disability Strategy and ACC's approach to Disability Support. The supplier will work with the client and their family/whānau to:

	Facilitated Pathway Map	Independent Facilitation	Tailored Supports	Coaching for Self-management
Expected client outcome	***Know their vision***	***Know their community***	***Build capability***	***Have choice & control***
Client actions	Explore, understand, aspire, articulate, identify, envisage, co-create	Investigate, understand, identify, choose	Set goals, make a plan, learn skills, develop relationships, participate, engage, connect, create, access, achieve	Understand, choose, decide, manage
Supplier actions	Facilitate, support, develop, co-design, produce	Facilitate, support, coach, establish, describe	Plan with, promote, encourage, support, enable, build capability, provide opportunities, link with, deliver, review outcomes	Review, establish, coach, provide, describe

Component	**Facilitated Pathway Map**	**Independent Facilitation**	**Tailored Supports**	**Coaching for Self-management**
Expected client outcome	***Know their vision***	***Know their community***	***Build capability***	***Have choice & control***
	The supplier will work with the client and their family/whānau to:	The supplier will work with the client and their family/whānau to:	The supplier will work with the client and their family/whānau to:	The supplier will work with the client and their family/whānau to:
Good and Valued Life *Support the client to aspire to valued life roles & a good life*	• facilitate the client's exploration of their aspirations • facilitate the client's understanding of their valued life roles • support the client to envisage their life journey • support the client and their family/whanau's understanding the different parts of the client's aspirations to have an everyday life	• support the client to investigate how they will live the life they aspire to in their community • facilitate the client to identify the roles they need support to gain skills in	• develop a support plan tailored to the client's aspirations and valued life roles • enable the client to set goals that are meaningful to them • facilitate interventions that are age, stage typical	• review the client's strengths and capabilities to undertake the role and tasks required to self-manage • review with the client all the ACC resources on self-management • establish if the client understands the implications such as contractual rights, employer and legal responsibilities • coach the client to understand the services and supports that they could choose to self-manage
Friendships *Support the client to build relationships & friendships*	• support the client to identify their circles of support • support the client to explore desired relationships • support the client to identify networks	• establish the client's understanding of natural, mainstream, funded support options • support the client to identify current & future relationships that are important to them • coach the family/whānau to understand how they can support the client build relationships & friendships	• provide opportunities for the client to develop relationships that are important to them • build client capability to engage and connect with a range of people in their community	• establish the natural supports that are in place • establish funded family carer arrangements
Culture and Community *Support the client to build sustainable, real cultural & community networks*	• support the client and their family/whānau to articulate the cultural practices, values, relationships and roles, important to them • support the client and their family/whānau to articulate the roles and responsibilities within family/whānau and the nature of family/whānau relationships with the client • support the client identify their existing community networks, important to them	• support the client investigate resources, opportunities and support options that are available and affordable in the community • coach the client to be able to identify preferred local cultural, community and employment networks • support the client to be able to choose cultural & community support options	• build individual skills and capability to enable client to connect and engage in the community • build individual skills and capability to enable client to participate in personal, cultural, community and employment opportunities • ensure the client's cultural engagement optimises the physical, social, cultural, aspects of wellbeing • provide individual and group support, activities and programmes • provide activities and programmes as close to the community • proactively develop opportunities and partnerships to enable the client to engage in community-based activities and programmes • link with local organisations and employers to create cultural and community opportunities	• establish cultural roles and responsibilities within whānau and the nature of whānau relationships with the client

Component	Facilitated Pathway Map	Independent Facilitation	Tailored Supports	Coaching for Self-management
Expected client outcome	***Know their vision***	***Know their community***	***Build capability***	***Have choice & control***
	The supplier will work with the client and their family/whānau to:	The supplier will work with the client and their family/whānau to:	The supplier will work with the client and their family/whānau to:	The supplier will work with the client and their family/whānau to:
Safe and Well *Support the client to be well & safe*	• facilitate the client identify existing activities that are meaningful to them • facilitate the client to articulate what "safe" means and what are considered acceptable risks • support the client to identify what healthy and well means to them	• coach the client to identify areas of interest and local activities they want to engage in • support the client to be able to choose activities and interests to enable them to participate in everyday life • support the client to identify what they need to feel safe	• enable client to feel respected and valued as unique individuals • ensure client feels supported and listened to • build individual skills and capability to enable client to make decisions about their life • build individual skills and capability to enable client to engage in everyday life • build individual capability to overcome barriers to participation	• use supported decision making • establish if PPPR Act and Authority to act, is in place or required
Skills and Challenges *Support the client to learn new skills & manage challenges*	• facilitate the client's understanding of their personal strengths • support the client to identify existing strategies used to manage challenges	• support the client to identify their independence and daily living skills to enable them to participate in everyday life	• build individual skills and capability to enable client to learn new skills & increase level of independence • build strategies to build confidence, capability and skills to engage in their everyday life • build individual financial management skills • build strategies to explore transition from home to adult life	• coach the client to be able to access services & supports when they need them • establish which services and supports the client will need support to self-manage
Education and Employment *Support the client to achieve potential to access an education & be employed*	• facilitate the client identifying learning, education and employment aspirations • support the client to envisage learning, education and employment pathways	• support the client to identify local cultural, learning and employment supports	• provide opportunities for the client to develop cultural, learning and employment pathways • build individual skills to be "fit to leave" school, or tertiary study • build individual skills and capability to enable client to transition from school to learning and employment opportunities • support the client secure opportunities to participate in volunteering • enable the client to prepare for work trials and employment placement • support the client secure workplace-based experience/placement • provide coaching and support within the workplace • enable the client to explore innovative employment participation options, i.e. social enterprise options • link with local employers to create employment opportunities	• provide coaching in the aspects of self-management the client chooses to undertake themselves
Leadership *Support the client to demonstrate leadership*	• identify significant milestones and future life changes	• support the client to identify leadership roles in local community	• enable client to to build networks that work towards being an active member of their local communities	• coach to direct supports
Choice & control *Support the client to make informed choices and decisions* *Use appropriate supports and technology to ensure supported decision making*	• co-design and produce a visual map of the client's vison of what their journey might look like	• describe in the summary the client's choices about what their local support options will include • describe in the summary the client's choices about who will provide their disability support	• plan with the client set their meaningful participation goals • review progress and outcomes across the client's life roles	• describe in the summary the client's choices about the types of ACC services and support the client has chosen to self-manage, and/or have support to self-manage, as per documentation in ACC's self-management processes

8.2. Information for clients and family/whānau

The supplier will:

- explain to the client and their family/whānau the philosophy and principles underpinning Living my Life
- ensure the client and their family/whānau are informed of what to expect throughout the delivery of the Living my Life service component
- deliver support that is meaningful to the client, their family/whānau and respects their identity and diverse values
- ensure the client choses which of their family/whānau and broader circle of support will play a key role in their disability support
- alert the ACC recovery team member of any needs/issues/risks or vulnerabilities identified while working with the client
- link with other service suppliers to ensure the continuity of the goals the client is working on. *Case conferences maybe considered*
- keep the recovery team member up to date as per the communication plan.

9. Facilitated Pathway Map

9.1. Purpose

The purpose of the Facilitated Pathway Map component is to:

- enable the client to explore their aspirations and understand what is important to them
- describe their vision, path and milestones of what their journey will include
- co-design a visual aid to make it easy for the client to explain to other people what their journey might look like.

9.2. Goals

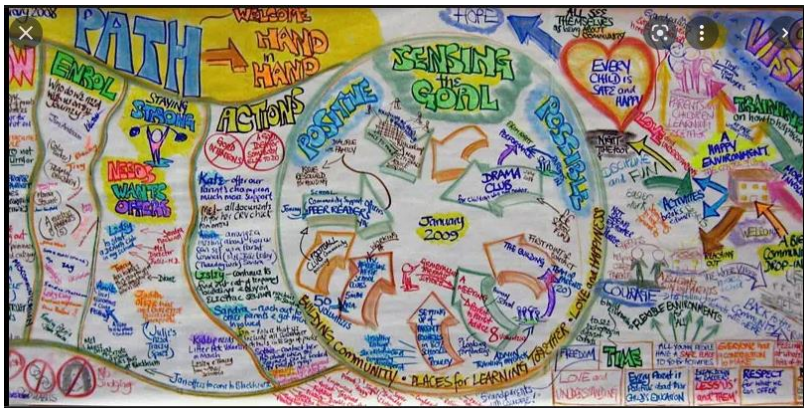
The goal of the Pathway Map is for the provider to enable the client to understand their:

- aspirations and vision for the future
- potential life domains and life roles
- circles of support and desired relationships
- personal, cultural, community and employment supports
- networks and how these could look in the future
- what meaningful engagement and participation should look like.

9.3. Outcomes

The outcome of the service is the delivery of a visual Pathway Map that:

- the client has co-designed, understands and is happy with
- reflects who they are and what they want
- makes it easier to talk with people about what they want
- supports decision-making about choice of supports and the people who provide them
- assists with further goal-setting with providers of services and support.



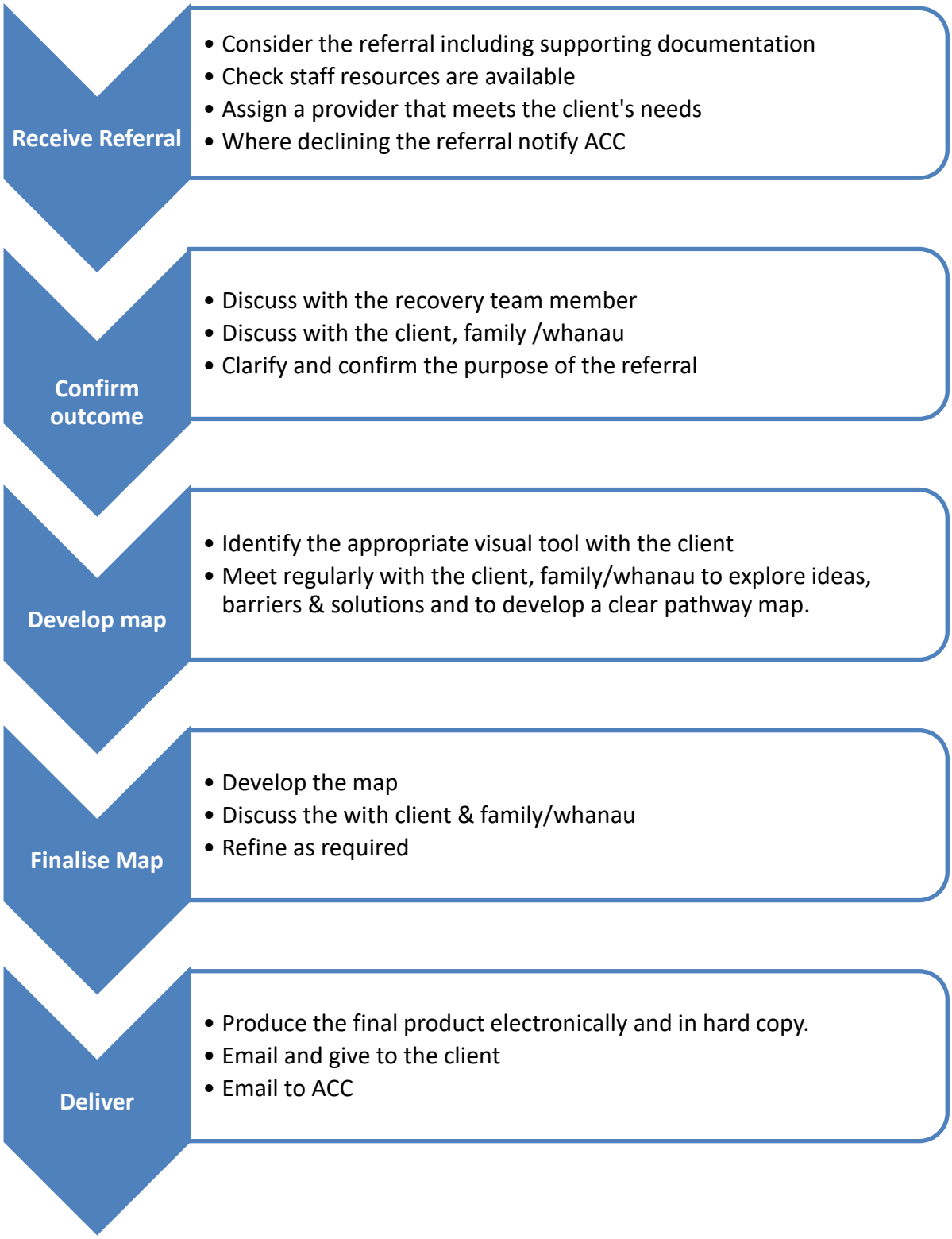
[Person centred planning]

This link is to a Path website which methodology this service component is based on.

The sector suggests that this method or technique of personal and group goal setting is now the standard.

Note: The image above is a generic example of how a pathway map could look. Suppliers who have not learnt this technique are encouraged to do so for better client outcomes.

9.4. Business Process Map



9.5. Inputs

The supplier may use up to 15 hours to develop an individualised map with the client. This includes all the consultation, exploration and iterative design of the map and includes liaising with ACC and others. The supplier will invoice only for these hours.

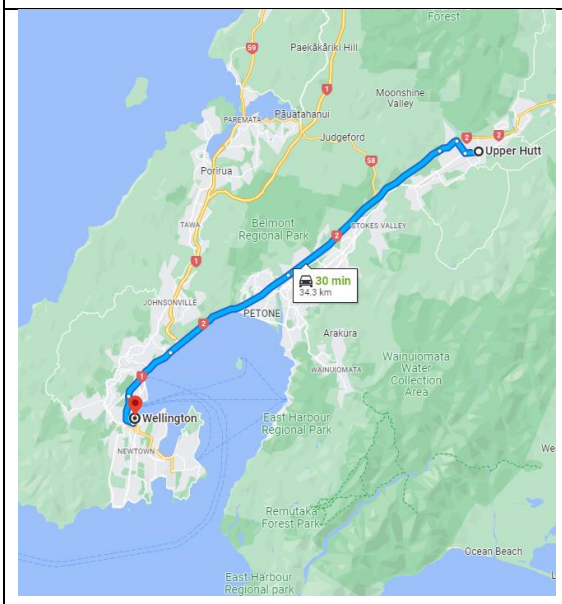
Service administration and overhead costs is built into the composite hourly rate and cannot be invoiced for separately.

9.6. Activities

The supplier will provide the following activities:

- Use co-design tools to explore a client's aspirations about how they want to live their life and understanding what their journey might look like.
- Collaborate with the client and their family/whānau in the process to understand the client's aspirations about what their:
    - natural and community circles of support could be
    - natural, universal, mainstream and funded supports could be.
- Create a visual map with the client.

Example – A difference between a visual map and list of steps or actions

✓ Visual Map	✘ A list
	30 min (34.3 km) via State Hwy 2 Fastest route, the usual traffic Upper Hutt Follow Fergusson Dr and Whakatiki St to State Hwy 2 in Trentham 3 min (2.1 km) Follow State Hwy 2 and State Hwy 1 to Taranaki St in Te Aro, Wellington 25 min (31.8 km) Turn left onto Taranaki St (signs for Civic Centre/Oriental Bay) 2 min (400 m) Wellington

9.7. Case Study

Person	Funny, kind and shy are the ways Sela describes herself and as a young 24-year-old woman she wants to start planning what her life might look like going forward. She is keen to build new friendships, get a flat and a part-time job.
Living environment	Sela lives with her parents and siblings and is part of the extended Tongan community. Sela's family provide most of her support and are concerned that Sela may put herself at risk when out in the community and away from her close circle of support.
Disability / ability	Sela had a car accident which left her with a moderate to severe TBI and hemiplegia.

	Sela can manage some of her personal care and helps her family around the house. Sela uses technology for some of her communication and enjoys games and music on her tablet computer. Sela needs support for some of her personal care. Sela needs encouragement to plan, initiate and consistently do activities at home. She participated in a community rehabilitation programme a few years ago. Sela is attending a Supported Activities programme two days per week where she attends an art group, practices using public transport to indoor bowls and does meal preparation. This increases her confidence and ability to build friendships and access the community.
Impact	Sela lacks insight, has reduced problem solving skills and presents with behaviours of concern.
Function	Sela finds it hard to understand too many things at once and struggles with problem solving. She feels that she has lost a lot of confidence and finds it difficult to cope. Sela knows that sometimes she has put herself at risk because she is very trusting and vulnerable to pressure to engage in risky behaviour. Sela wants to go places and try new things easily. Sela uses a powered wheelchair and has a modified vehicle that her mother drives to get out and about.
Provider action	The provider works with Sela and her extended family over a number of sessions at Sela's home. The sessions focus on developing/drawing a picture (visual map) of what is important to Sela, what things she must do and what support she will need on her journey to make this happen. The provider takes a strengths-based approach to identifying with Sela her strengths and challenges. The provider leads everyone to focus on what support Sela needs. The provider finalises the visual map and confirms that it represents her desired journey. The map is provided to Sela and her recovery team member.
Outcome	Sela is pleased the map shows her strengths and interests as well as the challenges she has to learn to manage. Sela is pleased that she can take her map with her to her church group, community programmes and to the providers of her support.

10. Independent Facilitation

10.1. Purpose

The purpose of Independent Facilitation is to:

- enable the client to understand their local natural, universal, mainstream and funded support options and activities
- enable the client to find meaningful connections in their community
- facilitate the client to make choices about the activities and supports they want to engage in
- facilitate the client to make choices about the providers of their support options.

10.2. Goal

The goal is for the supplier to:

- support the client identify local cultural, community and employment opportunities
- have choice and control of their support and who will deliver it.

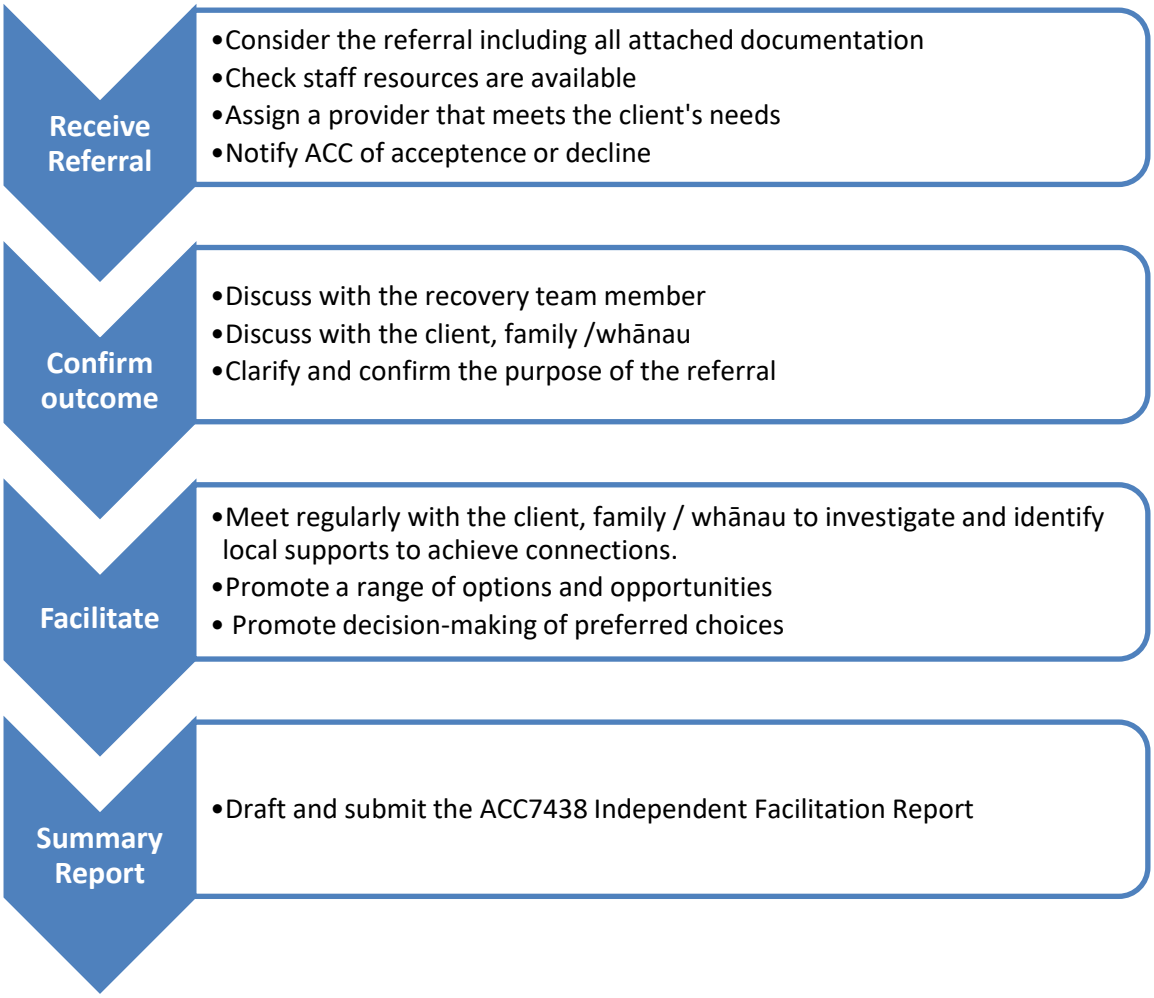
10.3. Outcomes

The outcome of this service component is the delivery of a summary of local resources and choices about the client's preferred supports and providers.

The client has:

- developed an understanding of their natural supports
- built genuine and sustainable natural networks
- developed an understanding of funded community services, resources and organisations to most effectively support them
- made informed decisions about how they would like to be connected to the community
- described their preferred support options to engage in their roles and meet their whole of life needs.

10.4. Business Process Map



10.5. Inputs

The supplier may use up to 15 hours to deliver the activities described in the Activities section. Service administration and overhead costs is built into the composite hourly rate and cannot be separately invoiced for.

10.6. Activities

The key activities are supporting the client and their family/whānau to:

Activity	How
Find information	Show them how to research and find resources in the community Library, local Council offices, Citizens Advice, online specific sites i.e. Parafed, Attitudelive, Independent Living service.
Connect better	Identify support networks in the community: - Using internet, library, pamphlets etc - via phone, email, face to face visits - visiting neighbourhood houses - visiting culturally specific organisations/Trusts - Access disability support services.

Get help	Office of the Public Advocate, WINZ, Carers NZ, Advocacy Groups.
Link to community resources	Link to community organisations such as Men's Sheds, community groups, Be.employed, Asian Network inc.
Contribute to the community	Identify opportunities to contribute to the community such as Disabled Persons Organisations, Enabling Good Lives, Be.Leadership, TASC – The Association for Spinal Concerns, Consumer Reps.
Make decisions	Make informed decisions about their disability support and preferred supplier/providers.
Build relationships	Building community relationships and strategies to address barriers to community and employment participation.
Increase independence	Identify supports and services that 1. family and whānau can help with 2. can be self-funded, or 3. are freely available or discounted in the community, or 4. may require ACC funding

10.7. Client reporting

The ACC7438 Living my Life Independent Facilitation report is provided to the recovery team member and the client at review points within the service. ACC uses the report to work with the client to support their decision making. The supplier will ensure that all relevant information is included and the report is complete. Explain any gaps.

The supplier and provider will ensure that ACC is kept up to date with the client's progress throughout the service as agreed at referral time.

10.8. Case Study

Person	Hēhu is a 30-year-old Māori man who describes himself as someone who always thinks about others and is happiest spending time at the rugby and at the Marae with his family and whānau. Prior to his injury he was a part time hammerhand and full-time rugby player who had goals of one day playing for the All Blacks. Hēhu spent a lot of his day training with his rugby team on the field and in the gym.
Living environment	Hēhu lives with his wife and two young children (5yrs and 7yrs) on a rural property in a home that has been modified to his needs. He has been working as a part-time teacher aide for the last 2 years at a local primary school. This is the only work he has done since his injury.
Disability / ability	Hēhu has paraplegia following a rugby accident. He went through the Spinal Unit, has had community rehabilitation and support with return to work.
Impact	Hēhu feels anxious that he is not supporting his family to the extent he would like and feels he now has the frame of mind to look at how he could extend himself.

	Hēhu has expressed a desire to do study to become a coach or a registered teacher and take on a greater role in his community. Hēhu is concerned that he does not have flexibility in the support he receives to do the things he wants to do.
Function	Hēhu has upper limb function and is able to transfer from floor to chair, he drives independently and is a very capable wheelchair user around his community. He also uses an all-terrain chair to get onto the beach and into the forest.
Provider action	A Kaitiaki from a local Māori Independent Facilitation supplier work with Hēhu to support his understanding of his options relevant to his whānau, haua support, and his local communities. The provider engages whakawhanaunga (connectedness) processes with whānau, applying knowledge and understanding of different roles and responsibilities within whānau, school and community.
Outcome	Hēhu re-thinks his personal care hours to work better with changing demands on his time. Hēhu identifies local training options and investigates ways his employer can support him to undertake some teaching papers. Hēhu identifies what leadership roles he can offer and those who can provide support (mentoring) within the community.

11. Tailored Supports

11.1. Purpose

The purpose of Tailored Supports is for the provider to:

- enable the client through the delivery of individual and/or group support to achieve meaningful participation outcomes, within the broader community.
- ensure a whole of life approach is taken and consider all the client's life roles for which there are participation goals.
- deliver support within the community that is meaningful to the client and recognises the importance client choice, diversity and real engagement in society.

11.2. Goals

The provider's objective is to enable the client to live an everyday life by building their

- **confidence** and self-determination
- **capability** to express themselves, make choices and follow through
- **relationships** – friendships, associations
- **community networks** and support

The development of the client's goals can be improved when they have already developed their pathway map using Facilitated Pathway Mapping. If the client doesn't have a pathway map or their map is out of date discuss the potential benefits for the client with the ACC team member.

In working with the client if you see that some of the services or supports are readily available in the community you can also suggest the client participate in the Independent Facilitation (IF) programme. IF is aimed at maximising the client's control and access to services and supports in the community that are not solely ACC funded.

11.2.1. Time to plan

ACC is purchasing a holistic, integrated programme of support for the client. Therefore, time spent with the client developing their goals, actions and activities is funded within the Tailored Support programme.

Planning and goal development with the client is not included the five hours provided for the drafting of the ACC7437 Tailored Support Plan.

Living My Life pricing using a com

11.2.2. Examples of Goals

The following examples provide a guide to writing the types of goals and actions that might fit in each of the four life domains. Not every domain will be relevant to the client's plan of tailored support.

The client's plan should use the **client's voice** to describe their meaningful goals. Their goals should reflect the **life roles** that are important to them to live their life.

These examples are the client's goals and do not include the supplier's actions in support of the individual goals.

The form completion guide for the ACC7437 Living my Life Tailored Support Plan shows how the supplier can describe their actions in supporting the client to achieve their goals.

Where I live…	
Meaningful goals:	Agreed actions:
I would like to live in my own flat	I will investigate options about where I want to live & who with I will find out about the Ministry of Health "Four Go Flatting" programme I will apply for a HNZ house

Where I live…	
Meaningful goals:	Agreed actions:
I would like to live with another person/flatmate	I will work out what sort of person I would like to have as a flatmate I will find out how much I should charge and different ways I could to find a flatmate I will learn about my responsibilities, as a tenant
I want to be proud of where I live and invite my family to spend time with me	I will keep my home tidy so that I can make other people comfortable I will choose some recipes that I can practice shopping for and cooking I will help at home by cooking a meal each week for the family
I want to have more confidence about saying what is important to me about how and I live	I will write down the things that I need to say and practice with my support worker before I share them
I want greater choice and control about my services and support, in my life	I will find out more about my services and support so I can make decisions about what I want

What I do…	
Meaningful goals:	Agreed actions:
I would like to be independent in looking after myself	I will practice doing more of my own personal care morning and night I will make a list of the household jobs and do these regularly I will attend any on-going appointments I need because of my injury
I would like to be able to manage my own money when I go flatting	I will work with my support worker to work out my expenses, my budget I will work on the skills that I will need - paying rent, banking, tenancy responsibilities
I want to take responsibility for my actions	I will work with my whānau and my support worker to get their support to make decisions and fix problems when they happen
I want to participate more within my own culture	I will join the Kapa Haka group
I would like to do more walking and become fitter	I will get a Green Prescription I will setup a reminder on my phone for 15 minutes before my walk I will practice going out to new places to manage my fears and increase my confidence when I go out. I will reward myself if I go out for my walk and feel good about what I have done I will attend the gym twice weekly
I want to get a job and earn some money	I will identify what my work interests are and what sorts of employment options are in my community I will find short courses or free courses near where I live

What I do…	
Meaningful goals:	Agreed actions:
	I will learn how to apply for jobs online I will review my CV and practice my interviewing skills I will work with my support worker to get a work trial to the Zoo
I would like to work part time	I will work out what type of work I could do I will work out what upskilling I may need I will work out how many hours I could work in in different jobs I will put flyers around the neighbours to see if their dogs need walking, lawns need mowing I will approach Workbridge, temp agency and apply for part time work. I will approach employers, trusts, volunteer groups to ask for voluntary work/work trials
I want to engage in more community-based activities	I will join the woodwork group at the community centre
I would like to keep playing music	I will get support to fix my guitar strings and work out a budget to do this I will make a list of songs I would like to learn to play I will practice playing my guitar
I would like to build my gardening skills	I will make a list of plants and garden materials I would need and work out a budget I will make a list of regular garden jobs I will do
I would like to build my confidence to work with animals	I will do some dog walking at my friend's business I will volunteer at the SPCA centre
I want to look after my puppy	I will find out what I would need to do to look after my puppy to keep it safe & happy I will set up reminders on my phone to feed and walk my puppy I will remember she is my responsibility and needs my love and care I will make a budget for any of the things a puppy would need and how much time I would need to care for it

Where I go…	
Meaningful goals:	Agreed actions:
I would like to visit local services to get accommodation information	I will visit local Disability Information Services, WINZ or Marae to find out about any support for people to get a flat I will go to local community organisations such as the Library, Citizens Advice and the Marae, to look for flatmates
I want to have more confidence to go out	I will build my skills to be more independent finding my way around in the community

Where I go…	
Meaningful goals:	Agreed actions:
	I will build my skills towards accessing public transport independently
I want to go to the Marae	I will take my guitar with me to social gatherings at the Marae
I would like to develop my gardening skills	I will visit the local garden centres to work on my inventory of what I will need for my garden I will look for local gardening community groups I could join
I would like to go to the dog park	I will visit the local dog parks with my support worker and decide which suit me and my puppy
I would like to go on a holiday	I will find out how to get my passport I will use the internet, library and travel agencies to find places that interest me I will work out a savings plan I will go on a fishing trip with my friend and my brother

Who with……	
Meaningful goals:	Agreed actions:
I would like to get along with my neighbours and my flatmate	With the support of my Tailored Support worker: I will work with my support workers on strategies to help positive relationships with my neighbours and flatmate
I would like to find and choose a flatmate	With the support of my Tailored Support worker: I will talk to my whānau and friends about people who might want to go flatting I will plan interview questions I will people who can support me choose a flatmate I will interview flatmates, with my brother and decide who I would like to live with
I would like to take on roles in my community and be take a greater part within my own culture	With the support of my Tailored Support worker: I will spend more time with my whanau and at the Marae
I would like to play music with people who are important to me	With the support of my Tailored Support worker: I will invite two of my friends to play music with me, regularly
I would like to share my garden and produce that I grow	With the support of my Tailored Support worker: I will share my produce with my flatmate I will cook and eat the food that I grow
I would like to make friends for me and my puppy	With the support of my Tailored Support worker: I will work with my support worker to engage appropriately with other dog owners at dog parks

I want to spend more time with friends and family and take holidays together	With the support of my Tailored Support worker: I will plan my next holiday with family and friends

11.3. Outcomes

The outcome of this service component is the delivery of disability supports that will enable the client to be able to:

- build genuine relationships, friendships and local natural & cultural networks
- build interests and choose meaningful individual and group activities and supports
- describe meaningful goals and review and change the goals as skills and abilities develop
- actively create innovative ways to connect to the community, work opportunities and who to live with
- actively engage in an everyday life and participate as others do at a similar stage of life.

11.3.1. Meaningful Goal setting and Outcome Measurement

The framework is designed to facilitate the vision of Living my Life: "Enabling self-determination about where I live, what I do, where I go and who with".

The goal setting approach has been structured to enable providers to articulate the client's agreed disability support, within an 'outcomes' framework.

Life domains	Goal setting	Goal Achievement rating
Where I live What I do Where I go Who with	Engage Anchor Negotiate Next step	Not meet or Status quo Partially meets aspiration Meets aspiration Beyond aspiration

The supplier will deliver individual and/or group community based Tailored Supports around "Where I live, what I do, where I go and who with".

The client's Individual Plan will detail goals set by the client with the ACC recovery team member. These may vary in layout and description of client objectives, goals and/or actions.

The Referral form will include the client goals made with ACC against the four life domains. These should be copied from the Referral form to the Tailored Supports Plan.

The goal planning approach used in Living my Life is based on the meaningful goals approach developed by AUT - *HeatlhMAP* *

HealthMAP takes an iterative approach to goal planning and supporting goal-directed behaviour. Meaningful goals evolve as the client gains skills and strategies.

For an episode of Tailored Supports the *HealthMAP*[1] approach is embedded in the Tailored Supports Plan.

[1] [1] McPherson, K.M., **Kayes NM**, and P. Kersten, (2014). *MEANING as a Smarter Approach to Goals in Rehabilitation*, In Levack, W. and Siegert, R. (Eds.) *Rehabilitation Goal Setting: Theory, Practice and Evidence.* CRC Press, Taylor& Francis: Boca Raton.

Goal Setting

- Engage - co-produce goals that are meaningful to the clients and their family/whānau, in terms of their aspirations, cultural relationships and connection to the community
- Anchor - detail actions against each goal
- Negotiate - regularly review the goals and actions and identify barriers, make ongoing adjustments and negotiate iterative goals across the episode of Tailored Supports
- Next step - identify goal achievement by rating the attainment at the review of an episode.

Outcome Measures

- Not met or Status quo
- Partially meets aspiration
- Meets aspiration
- Beyond aspiration.

Example of Meaningful Goal setting:

Meaningful goals (engage)	Actions (anchor)	Review (negotiate)	Outcomes (next steps)
"Where I live"			
I would like to learn things I need to go flatting with my cousin	I will work with my support worker to make a weekly budget, and manage my own spending I will join the life skills activity groups and also practice these at home I will find out how much it would cost to get a flat with my cousin	I will learn how to pay my own bills At home I will do my own meals and clean my room and the bathroom and do my washing I will work with my support worker & cousin to look at accommodation options such as private rental/housing NZ	Where I live outcome: My Uncle and Aunty have put a kitchen in the downstairs part of their house where I can live with my cousin Next steps: Work out with my support worker and cousin: • a timetable of my house duties • shopping list & cooking plan • calendar of bills/rent to be paid

Additional outcome areas included in the Tailored Supports plan:

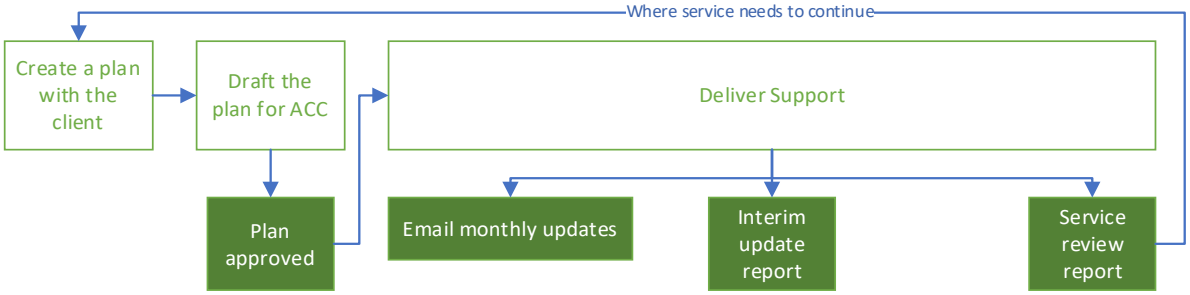
Review against the Living my Life principles:	• Person-directed - I have more choice & control? • Whole of life - My supports are tailored to me? • Connectivity - My supports connect me to my community? • Embracing diversity - My supports are about what is important to me? • Citizenship – I am making the decisions about my roles in my life?

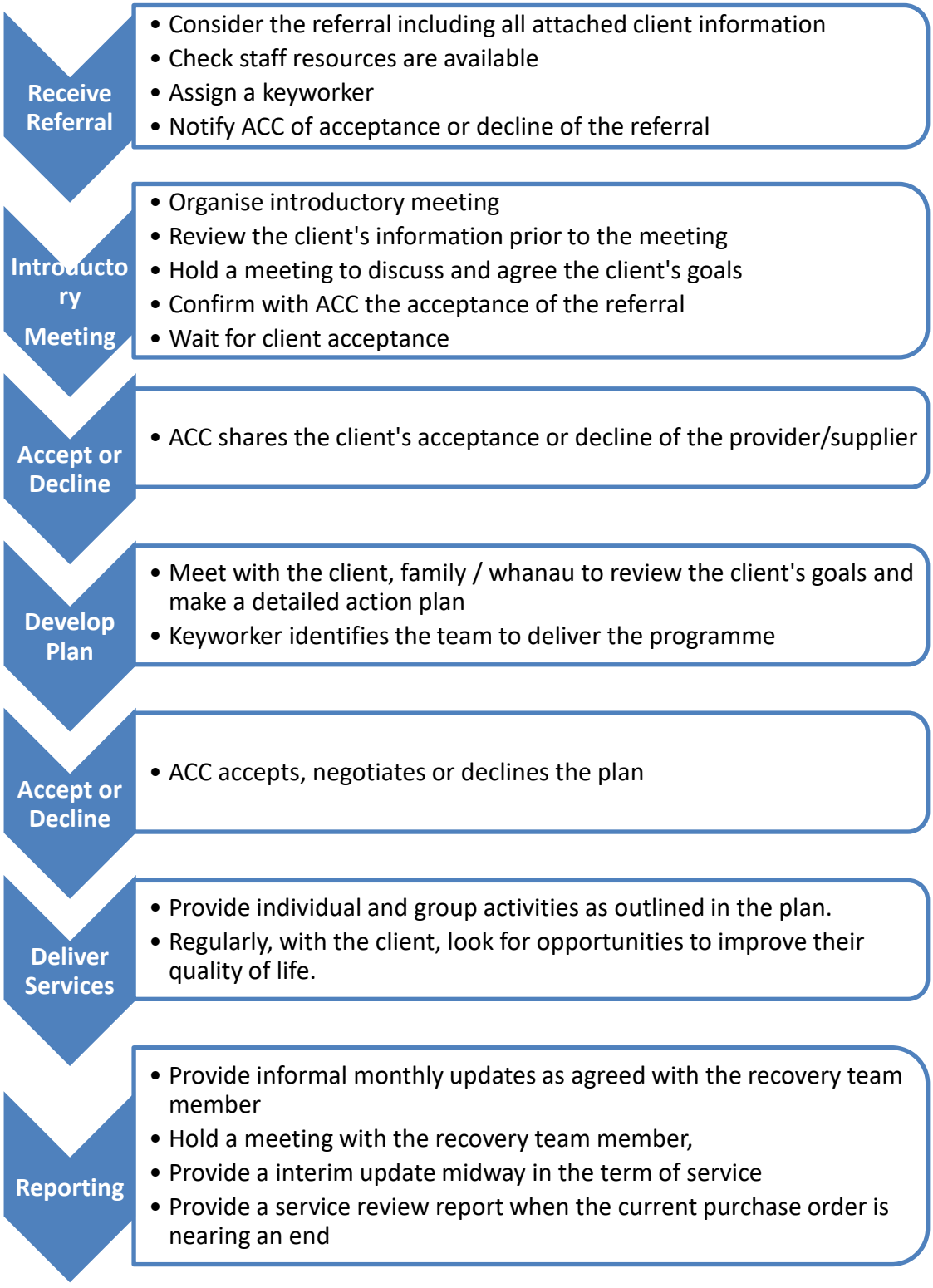
Review against positive change in client circumstances. *(Results Based Accountability Better off data codes)*	• Skills & knowledge change • Attitude & opinion change • Behaviour change • Circumstance change

All Tailored Supports suppliers must complete the Interim update and Review section in the ACC7437 Report template outlining the Goal achievement and recommendations for further support.

11.4. Process

This process guide describes what is most likely from the supplier's team.





11.5. Inputs

Tailored Supports can be delivered up to whatever is agreed on the purchase order depending on the client's needs and their goals. It is expected that the hours listed in the purchase order are spent with the client, family/ whānau delivering disability support that promote active engagement.

The purchase order will be based on the agreed Tailored Supports Plan. The supplier will invoice only for the time spent.

Notes:

It is expected that the

- provider will need to actively engage and build their own community networks and partnerships to deliver client personal, cultural, community and employment participation outcomes.
- **suppliers** will deliver a **mix** of individual and group activities.

11.6. Activities

Throughout the delivery of Tailored Supports the supplier is:

- Planning, goal setting and reviewing outcomes with the client
- Making opportunities to engage family and whānau as agreed with the client
- Empowering families to use supported decision-making to enable client choice
- Delivering facilitation, coaching, guidance, prompting and providing opportunities to practice strategies by engaging in interests and activities
- Encouraging the gaining of new skills, practice skills and take initiative towards functional independence
- Encouraging development of genuine friendships, relationships and circles of support
- Supporting the client's exploration of new opportunities to develop interests, learning and employment options
- Facilitating client in decision-making to enable choice and control
- Linking with supports in the client's community to facilitate the client's access and integration
- Providing a wide variety of opportunities for the client to explore what interests them
- Reviewing client and family outcomes to ensure the client has the greatest opportunity to improve their quality of life.

Example

The supplier will set and deliver interventions and activities that will support the client to achieve the actions they have set to achieve their goal "to learn things I need to go flatting with my cousin":

Where I live –establish option of an independent living space at home; make a list of what would furnishings/space would be needed; visit supported housing providers; visit advertised rental accommodation; develop a budget

What I do – practice strategies to increase independence in personal care; set up daily reminders on smartphone, provide activity group to do meal planning and cooking; support at community gardening group; encourage activities that develop interests; practice strategies managing behaviours in new situations

Where I go – establish what a daily routine should look like; practice use of public transport; support to use community resources such as budget advisory service; support to resume pre-injury recreational activities

Who with – engage with cousin and key family/whānau supports, provide opportunities to build friendships; re-establish cultural opportunities and links.

11.7. Client Reporting

The ACC7437 Living my Life Tailored Supports report is provided to the recovery team member and the client on reviews of the service. ACC uses the report to work with the client to support their decision making. The supplier will ensure that all relevant information is included and the report is comprehensive. Explain any gaps.

The supplier and provider will ensure that ACC is kept up to date with the client's progress throughout the service as agreed at referral time.

11.8. Case Study

Person	Jamie is a 17-year-old who lives at home with her parents and 3 younger siblings. Jamie attends her local high school, is sociable and has some good friends at school but does not have a lot of friends outside school.
Living environment	Her family house is one level modified home. Jamie attends school 5 days a week but does not attend after school activities and rarely has interactions with her school friends on the weekends.
Disability / ability	Jamie has Cerebral Palsy, she uses a power wheelchair for mobility and assistive technology to support her communication and production of written work at school. Jamie is achieving educationally and her individual education plan is more about access around school, using her assistive technology.
Impact	Jamie says she lacks confidence and withdraws when she is with people she does not know due to her difficulties communicating verbally. Jamie is starting to prepare to transition from school into adult life and would like to one day live with other young people. Jamie is concerned that she will not have the belief in herself to do the things she knows other young people her age are doing. Jamie is not sure what would be involved in living with other young people her own age and how her need for support and use of equipment to get around would impact on making this happen. Jamie can access career advice through school. She is unsure of what sort of study or work she would like to do once she leaves school.
Function	Jamie requires an accessible environment and transport support. Jamie is bright and would like to be studying and go flatting before she is 25.
Provider action	The provider Jamie chose focuses specifically on support options for young people to live independently with supports and delivers a youth programme in the community to enable social experiences. Jamie works with her support worker on building a range of new skills she would need if she were to live independently including planning and shopping for what she needs for the week; understanding her budget, doing her own banking and using the computer. Jamie also works on developing her interests in group settings, going out with friends from school on the weekends and with the youth group to community activities and events.
Outcome	Jamie works with the provider and her family to review her goals and agree next steps as she builds her confidence, networks, and abilities to engage in the community. Following on from her initial meetings with her careers advisor at school, she has requested some support with looking

	at work experience and options for the year after leaving school with a plan.

11.9. Introductory meeting

The supplier will organise an introductory meeting with the client, their family/whānau and the ACC recovery team member. This meeting is used to confirm:

- The client's ACC participation goals
- The supplier's capacity to support the client to achieve their goals
- An understanding by the client about how the supplier would work with them towards participation outcomes.

The expected outcome from this introductory meeting is either:

- Agreement to proceed by both parties

  OR
- A decision to not proceed by either party.

11.10. Support Plan

Following the introductory meeting and acceptance of the referral, the supplier will set up a meeting with the client, their family/whānau to develop the Support Plan which reflects the client's:

- aspirations (refer to Pathway Map if this has been developed)
- participation goals, with reference to the objectives the client may have agreed with ACC
- roles they want to work on (where I live, where I go, what I do and who with)
- knowledge of their local community, cultural networks, circles of support (refer to Independent Facilitation Summary if this has been developed)
- knowledge of Self-Management and interest in using Self-Management in the future, if the client has participated in a Coaching for Self-Management programme.

Following the meeting the supplier will submit a Support Plan in the relevant section on the Referral Form ACC7437.

11.11. Approving the Tailored Support Plan:

Within 10 business days following the Introductory meeting with the client the supplier must provide ACC with the Tailored Support Plan.

Once ACC receives the Tailored Support Plan from the supplier, they will approve or decline the Plan and notify the suppler within 2 business days or request additional information.

ACC considers:

- Whether the Plan reflects the ACC Individual plan objectives, the discussion at the introductory meeting and the referral
- Any reasons why the Plan may differ from the intent of the referral and assess whether the reasons are robust and driven by the meaningful goal setting approach

- How the support will improve the client's participation across the life domains
- How the support will increase use of natural community supports as the client achieves their participation outcomes
- In the case of a client receiving both individual and group supports, how the support is structured to facilitate a focus on individualised community-based support.

11.12. Continuing to meet client need

When the current purchase order for the client's Tailored Support programme is nearly finished and the client continues to need the Tailored Support programme, the supplier will arrange a meeting with the client, their family/whānau and their ACC recovery team member to discuss how the client felt the programme went and to consider any immediate and/or long-term service needs.

Where it is collectively determined at that meeting that the client is likely to need ongoing services, the supplier may request that a new purchase order be created to fund the preparation of the new Tailored Support plan.

While a new purchase order is provided for the plan completion, this does not mean ACC is committing to continued funding of Tailored Support. ACC will decide on future funding based on the Tailored Support plan provided.

11.13. Service Responsibilities

While the client is participating in the service the supplier is responsible for:

All personal care	For provision of personal care, although the client should bring any personal care consumables with them.
Medication management	The delivery of medication as required, although the client should bring their medication with them.
Privacy and respect	Ensuring the client and their family/whānau are treated with respect and their privacy and dignity is maintained.
Accessibility	Ensuring the client has access to and can use suitably accessible facilities where the client is engaged in an activity in the community or a community-based facility.
Transport	Ensuring the client can reasonably and affordably access the community and activities that are suggested.
Health and Safety	Ensuring that the environment where the activities take place is safe for the client and compliant with H&S standards

12. Coaching to Self Manage

12.1. Purpose

The purpose of this service component is to provide coaching and support to:

- enable the client and their family to understand self-management
- make a decision regarding readiness to self- manage their own day to day supports and services or not, and,
- if they choose to self-manage, support the client while they become self-managing.

12.2. Goals

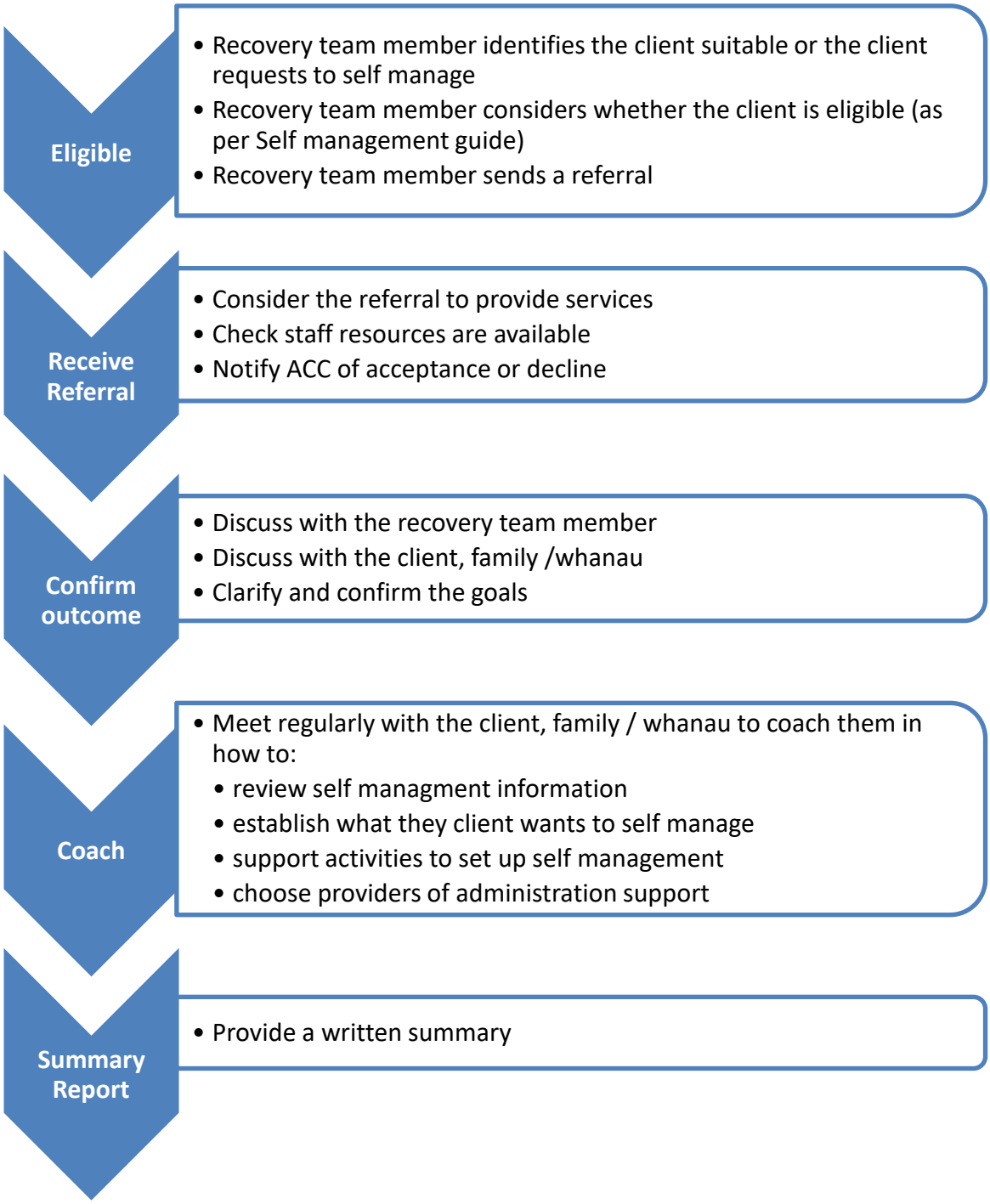
The goal of this service is to support the client to determine their readiness to manage their own services, supports and budget, and support the activities required to implement self-management.

12.3. Outcomes

The outcome of the service is the delivery of a summary report outlining the client's readiness to self-manage and if ready the client:

- has decided what service items/ services to self-manage
- understands how they will manage services and supports
- understands the support available to help them manage their agreed package of supports
- understands the implications and responsibilities of managing their services and supports
- has made a considered decision on whether managing it themselves is the right option for them, and/or
- has developed the skills to actively manage their services, support and funding.

12.4. Business Process Map



12.5. Inputs

The supplier may use up to 15 hours to deliver the activities described in the Activities section. Service administration and overhead costs is built into the composite hourly rate and cannot be separately invoiced for.

12.6. Activities

Supporting the client and their family/whānau and to access information and understand how they could use ACC Self-management:

- Review package of ACC Self-management documents - Self-management guidebook & Self-assessment form
- Review medical consumables process
- Establish what Self-management menu items the client would like to self-manage.

Supporting the client to make decisions about type and amount of support needed to self-manage their ACC budget, services and support:

- Ensure the Client understands tasks required to set up self-management such as monitoring their budget; keeping records, being an employer; doing payroll payments.

Supporting the client to undertake required tasks to enable recovery team member to set up Self-Management in ACC systems:

- Support client to compile proof of address & copy of ID and that these are certified by a JP
- Set up the bank account
- Facilitate meeting with ACC recovery team member to Self-management plan & confirm budget.

Empowering the client to make decision about their preferred supplier of support to self-manage the administration, recruiting, budgeting and employer role, if required:

- Identify a provider of services to support administration aspects of chosen package.

Provide recovery team member with summary report describing:

- Client's understanding of self-management (including if client is ready)
- Support to complete requirements to self-manage
- Summary of chosen services and any support required.

12.7. Client Reporting

The ACC7439 Living my Life Coaching to Self-Manage report is provided to the recovery team member and the client on completion of the service. ACC uses the report to work with the client to support their decision making. The supplier will ensure that all relevant information is included and the report is complete. Explain any gaps.

The supplier and provider will ensure that ACC is kept up to date with the client's progress throughout the service as agreed at referral time.

12.8. Case Study

Person	Frank and his wife Betty recently retired and were planning on moving to a retirement village and have plans do their family tree, travel and spend time with their grandchildren. Frank was an accountant in his working life and has always been an avid user of the latest technology.
Living environment	Frank and Betty still live in the family home but are looking to downsize and possibly shift to a retirement village. Their son and daughter and their families live in the same city as them and they often have their 2 school aged grandchildren come stay with them during the weekends and school holidays.

Disability / ability	Frank had a stroke during a medical procedure. He has a left sided weakness and uses a walker at home and a wheelchair when out and about in the community and other pieces of equipment at home. He uses a number of consumable products and needs some attendant care to support with showering, dressing and mobility. Frank has worked hard during rehabilitation to develop strategies and manage the impacts this has had on his life such as remembering things, day to day communication and getting around as independently as possible.
Impact	Frank's fatigue, mood and lack of confidence is affecting how Frank feels about returning to managing his financial affairs with his wife and enjoying his retirement.
Function	Frank had a stroke during a medical procedure; he has a left sided weakness and uses a walker at home and a wheelchair when out and about in the community. He has no cognitive impairment but does have some fatigue and mood issues.
Provider action	Frank would like to have more control over how he gets his personal support and the equipment he uses. Frank and his wife work with a Coaching to Self-Manage provider to understand if ACC's self-management option would suit him and what is required to get it working for him.
Outcome	Frank decides that now he knows his budget and what he can self-manage that he will go ahead and manage all his equipment needs and consumables himself. Frank feels that aspects of managing his personal care such as payroll responsibilities are not things he wants to do. He elects to use a provider of individualised funding administration to manage the more administrative functions under his direction.

13. Service Quality

13.1. Accrediation & Memberships

The Supplier will have and maintain their organisational membership to New Zealand Disability Support Network (NZDSN) and/or Inclusive NZ.

Profession	Qualifications	Registration
Counsellor	Diploma, Bachelor, Masters or Post Graduate Qualification in Counselling	NZ Association of Counsellors
Occupational Therapist	Bachelor of Health Science (Occupational Therapy); or Bachelor of Occupational Therapy	Occupational Therapy Board of NZ
Physiotherapist	Bachelor of Health Science (Physiotherapy); or Bachelor of Physiotherapy; or Bachelor of Physiotherapy with Honours.	Physiotherapy Board of NZ

	If from overseas: 4 year full time undergraduate physiotherapy degree programme (sufficiently similar to NZ programme); or 3 year full time undergraduate physiotherapy degree programme with minimum 1 year fully registered, supervised physiotherapy experience or evidence of successful completion of university level physiotherapy qualification (i.e. Graduate Diploma, Post Graduate Diploma, Masters); or Diploma of Physiotherapy (non-University based) with evidence of successful completion of university level physiotherapy qualification (i.e. Graduate Diploma, Bachelor Degree, Post Graduate Diploma, Masters); or Graduate entry level physiotherapy qualification with a minimum 1 year full time, supervised physiotherapy experience plus completion of competence examinations at a NZ School of Physiotherapy; or If from Australia: Hold full registration and entitled to practice physiotherapy in any Australian state of territory.	
Psychologist	A minimum of a Master's Degree in Psychology from an accredited educational organisation, and registration or An equivalent qualification.	Psychology Board of NZ

Profession	Qualifications	Registration
Psychotherapist	Diploma, Bachelor, Masters or Post Graduate qualification in Psychotherapy; and Membership of the New Zealand Association of Child and Adolescent Psychotherapists (Incorporated); and/or New Zealand Association of Psychotherapists	Psychotherapist Board of Aotearoa New Zealand
Registered Nurse	A Bachelor degree in Nursing approved by the Nursing Council of New Zealand; or A Graduate Nursing qualification at Level 7 on the New Zealand Qualifications Framework approved by the Nursing Council of New Zealand; or A Post Graduate Nursing qualification at Level 8 on the New Zealand Qualifications Framework approved by the Nursing Council of New Zealand; and a pass in assessment of Nursing Council Competencies for Registered Nurses by an approved provider; and a pass in an Examination for Registered Nurses set by the Nursing Council of New Zealand.	Nursing Council of NZ
Social Worker	Bachelor of Social Work; or	ANZASW; or

	Masters in Applied Social Work; or Bachelor of Applied Social Work; or Bachelor of Bicultural Social Work; or Bachelor of Social Practice; or Poutuarongo Toiora Whānau.	Social Worker Registration Board of Aotearoa/New Zealand
Speech Language Therapist	Bachelor of Speech and Language Therapy; or an equivalent Bachelors or Master's degree from an NZSTA-accredited programme; or Those trained in NZ with a Teachers' Certificate endorsed with qualifications in speech and language therapy	New Zealand Speech Language Therapists Association
Support Worker	NZQA Level 4, 5 & 6: Health and Wellbeing; or Brain Injury Support	N/A

13.2. Provider experience

The supplier will ensure:

- All staff must have an appropriate understanding of disability practice methodologies.
- Clinical staff must have a minimum of two years of experience in community disability supports or community rehabilitation.
- Staff who do not have two years' experience are supervised until the staff member has gained two years' experience.
- The supervisor is qualified and has at least five years of experience in community disability supports or community rehabilitation.

13.3. Provider Supervision

Providers working in the helping professions whether allied health worker, social worker, counsellor, childcare worker, field worker, support worker or manager benefit from regular external supervision. The supervision helps providers to reflect on their practice and build their knowledge and skills to ensure the people they're working with receive the best possible care and support. Clinical supervision supports a provider's development both professionally and personally.

All service providers delivering services to clients are expected to have the supervision expected by their profession.

The supplier will ensure all support workers have the appropriate supervision and reflective practice that support the delivery high quality services to clients.

13.4. Quality Management Plan

Every supplier is expected to have a quality management plan that ensures all clients receive the highest quality service delivery including:

- timely services

- professional and highly competent providers
- excellent communication
- rapid and comprehensive problem resolution.

In addition to the requirements at clause 8.16 of the Standard Terms and Conditions, the Supplier will assess the client's health, safety and outcomes risks throughout the service delivery and will develop strategies to mitigate/minimise those risks. Where significant risks and mitigations exist, the Supplier will provide ACC with a copy of the Risk Management Plan.

The Supplier's complaints management system will be consistent with the Health and Disability Commissioner's Code of Rights.

If, for some reason, the usual Service cannot be delivered, the Supplier will arrange alternative Service as part of contingency planning for the Client so that they receive any services essential for safety. This includes:

- When the support worker is on leave or unable to attend;
- On public holidays;
- In case of natural disaster or publicly declared pandemic.

Suppliers are responsible for ensuring they or their staff reports all incidents and adverse events in the online tool available at www.acc.co.nz/for-providers/report-health-safety-incidents within 24 hours of identifying the issue or risk.

The Supplier will have a documented Quality Improvement Plan for their service delivery.

The Supplier will have a documented Risk Management Plan which will include evidence of management and mitigation of any identified risks to:

- Clients;
- Service Providers' health and safety; and
- Service delivery.

The Supplier will provide its Quality Improvement and Risk Management Plans to ACC on request.

13.5. Culturally competent services

The supplier will provide services that improve health and wellbeing by integrating cultural practices and concepts into service delivery. Clients will receive culturally safe services which recognise and respect their cultural and spiritual values and beliefs. Information is communicated in a manner to clients that they and their whānau understand.

To enable the provision of culturally competent services:

- The provider should have appropriate policies and training programmes that reflect cultural competency
- There should be a cultural component in the assessment and documentation for clients.
- The provider should collect ethnic data to show an understanding of their client group.

For more information see the ACC1625 Guidelines on Māori Cultural Competencies for Providers.

14. Performance management

14.1. Results Based Accountability

Results Based Accountability (RBA) is a simple, practical way for ACC to evaluate the results of these services. The question 'How are our clients better off as a result of our work?' is central to RBA. There is more about the RBA framework on these websites - MoH Results Based Accountability and NZ Government Procurement. Results Based Accountability™ was developed by Mark Friedman, author of *Trying Hard Is Not Good Enough*.

An example of the performance measures in the Service Specification is provided in the table below. ACC will work collaboratively with suppliers to develop performance measures that are fit for purpose. The Service Specification and Operating Guidelines will be updated once the performance measures have been finalised.

ACC will measure the success of this Service based on the following objectives:

RBA Model	Service Objective	Measure and Targets
How much did we do? *Typically count clients and activities.*	**Clause 2.1.1** The client is enables and empowered to produce and work toward achievement of meaningful goals that lead to personal, community and employment participation outcomes.	• Number of clients • Number and type of service components • Client demographics • Client cohorts
How well did we do it? *For each activity there are one or more measures that tell how well that particular activity was performed, usually having to do with timeliness or correctness.*	**Clause 2.1.3** The client is satisfied with the supplier's service.	• Percentage of Tailored Support Clients reported achieved and partially achieved their meaningful goals. • Number of days from Service commencement to Service review • Percentage of referrals accepted within Service timeframe • Percentage of Support Plans submitted within Service timeframe
There are a set of common measures that apply to many different programs and activity specific measures: • Number of Clients served • Number of Services provided • Number of days from Service commencement to Service review • Percentage of referrals accepted within Service timeframe • Percentage of Tailored Supports Plans submitted within Service timeframe • Percentage of Tailored Supports completed within 6 months • Percentage of Clients satisfied with the Service		

RBA Model	Service Objective	Measure and Targets
• Percentage of Tailored Supports Clients reported achieved and partially achieved their meaningful goals		
Is anyone better off? *These measures usually have to do with one of these four dimensions of better-off: Skills/knowledge, Attitude, Behavior and Circumstance.*	The Client is satisfied with the supplier's service. N.B. The aim of the survey is to continuously improve the supplier's service and therefore client outcomes. The supplier can survey throughout the year but will report annually.	**90% of clients are satisfied with the service.** Percentage of Tailored Support Clients reported achieved and partially achieved their meaningful goals Year 1 - 65% Year 2 - 75% Year 3 - 85% Numbers (#) Percentages (%) For each of these measures, we can use point in time measures or point to point improvement measures.
	The Client receives timely, efficient and effective services.	As measure by ACC • Cost per claim • Length of service • Length of time from referral to 1st service

14.2. Service Reporting

The supplier will report every six months to ACC via the Engagement and Performance Manager. The supplier will assess their own performance against the service objectives, timeliness and process requirements within the contract. The report will include:

- Number of clients served
- Percentage of referrals accepted within service timeframes
- Composition of the interdisciplinary team
- Percentage of providers who meet the qualification requirements
- Percentage of providers who meet the length of experience requirements
- Percentage of providers who are being supervised while they gain experience.

The supplier may also provide additional information such as case studies to show improved quality of life, quality improvement initiatives and service delivery issues.

14.3. Annual Outcome Report

The supplier will report each year to ACC via the Engagement and Performance Manager. The supplier will assess their own performance against the service objectives, timeliness and process requirements within the contract. The report will include:

- Number of clients served
- Number of services provided

- Number of days from service commencement to service review
- Percentage of referrals accepted within service timeframes
- Percentage of Tailored Supports Plans submitted within Service timeframe
- Percentage of Clients satisfied with the service
- Percentage of Tailored Supports clients reported achieved and partially achieved their meaningful goals
- Percentage of clients indicating readiness to self-manage
- Composition of the interdisciplinary team
- Percentage of providers who meet the qualification requirements
- Percentage of providers who meet the length of experience requirements
- Percentage of providers who are being supervised while they gain experience.

14.4. Service Results (Report No. 3)

ACC will provide a summary report annually. The content and format of the report will be developed in conjunction with contracted suppliers.

14.5. Supplier Days/Quality Forums

ACC will hold meetings periodically on a regional basis with suppliers. The meetings will cover operational issues, quality and service improvement discussions. The goal of the meetings is to enable suppliers and ACC to work in partnership to maximise the operation and outcomes of the service for clients. Where able, performance information may be provided to promote quality improvement.

15. Service Administration

15.1. Initial ACC Purchase order

To begin work the supplier must hold a valid purchase order (PO). Each component has its own requirements for the initial PO outlined here. The purchase order reflects the allowable total hours and the period of time the service must be completed in. The supplier should deliver only the hours required to meet client need and cannot exceed the maximum specified. Should the client require less time with the supplier than the maximum available the supplier will meet that need and consequently invoice ACC for only those hours delivered.

The hours engaged in the Service (other than the reporting hours) is funded via a composite rate.

The supplier should contact the recovery team member if circumstances require the purchase order to be amended. All requests for amendment should be supported by a robust explanation.

Service Item	Code	Initial Purchase Order	Subsequent Purchase Order
Facilitated Pathway Map	LML01	15 hours per referral	-
Independent Facilitation	LML02	15 hours per referral	-

Service Item	Code	Initial Purchase Order	Subsequent Purchase Order
Coaching for Self-management	LML03	15 hours per referral	-
Tailored Supports			
Introductory meeting	LML10	2 hours	-
Tailored Supports Plan	LML11	5 hours	-
– Individual Activities	LML12	-	As per the plan
– Group Activities	LML15	-	As per the plan *Maxi. of 4 hours per day except for approved activity programmes.*
Interim update report	LML18	-	Up to 2 hours
Closure report	LML19	-	Up to 3 hours

Suppliers should ensure the purchase order reflects the service agreement made with the recovery team member. If the purchase order is incorrect this will affect your ability to get paid. Ensure the service item codes, hours and timeframe are correct. If it is not, go back to the recovery team member and request it be corrected. Use the escalation process to resolve the issue if needed. You are within your rights not to deliver services until the purchase order reflects the agreed service plan.

15.2. Forms and Information Sheet

15.2.1. Forms

The Service has four forms.

Form Name	Description	Location
ACC7436 Living my Life Referral	Completed by an ACC recovery team member describing the client being referred and why they are being referred.	Under Review with ACC
ACC7437 Living my Life Tailored Supports Plan	Completed by the supplier outlining the support plan, interim update and service review report.	Link to ACC website
Form completion guide - ACC7437	Guide to the completion of ACC7437 Tailored Support Plan	ACC7437 Form Completion Guide.d
ACC7438 Living my Life Independent Facilitation Summary	Completed by the supplier summarising the facilitation provided.	Link to ACC website
ACC7439 Living my Life Coaching to Self-Manage Summary	Completed by the supplier summarising the coaching provided.	Link to ACC website

15.2.2. Information Sheet

Form Name	Description	Location
LMLIS01 Living my Life Information Sheet	Document explains what the Service provides	LMLIS01 Living my Life.docx

15.3. Service Location

Living my Life can be provided in the client's home, marae, school, workplace and/or other community-based community location.

Delivery of the Facilitated Pathway Map, Independent Facilitation or Coaching to Self-Manage delivery may occur at any of the above or the supplier's facility, where this is the client's preference.

Delivery of Tailored Supports should be where possible in a community setting that is age and stage appropriate, which accommodates family/whānau.

Where suppliers own or rent fully accessible environments, every effort should be made, to consider innovative ways to work in partnership to open these facilities (hubs) to the broader community.

Addressing societal barriers involves working in collaboration with universal, mainstream & culturally specific community organisations, disability networks and councils to create enabling environments that leads to connectivity and inclusion.

15.4. Service Coverage

The supplier will ensure they have all the staff they need to delivery all the service components they are contracted to deliver in every region they are contracting for.

In general, that is:

- **Support staff** - within 50 kilometres from the client's location
- **Allied Health** – within 150 kilometres from the client's location.

Where requested providers are outside of the above ranges, the supplier should discuss this with the recovery team member. See Travel clause of the Service Specification and Operational Guideline Section.

Use of information communication technologies (ICT) such as video-conferencing can be considered to provide follow-up and support where travel is prohibitive. This should only be considered where the plan very clearly identifies local community networks that are engaged to meet the participation outcomes.

15.5. Travel

ACC has agreed to pay for travel within each contracted area. The area being the territorial authority and the province description in Part A of the Service Specification.

ACC expects the supplier to have the appropriately qualified staff in the region or regions they have applied for. Where the region is particularly large such as the Waikato or Canterbury the

supplier is expected to have more than one team (and or team members) in the region contracted for.

In accepting the referral, the supplier will consider the cost of travel and ensure the closest available provider is considered first. If the client decides that the provider is not suitable then the next closest provider will be offered until the client is happy with their choice.

The supplier will discuss the situation with the recovery team member where the client has chosen a provider that is greater than 50km away, one way. The recovery team member may choose to try another supplier who may have suitable providers who are located closer to the client. In this situation, ACC, will close the purchase order and pay for service rendered

Topic	Description
Provider Travel to the Client	Where the provider is travelling from the facility or their own base to the client they can claim mileage and provider time. *This is described in detail below.*
Client Travel to Supplier's Facility	The client is responsible for getting themselves to and from the facility.
Travel to Activities	Where a client is travelling to planned activities with a provider in: • the client's car the client no mileage will be reimbursed • The provider's car; the supplier can invoice for provider time and kilometres Travel to/from activities from a provider facility base or hub and the costs of such activities are the responsibility of the supplier. Where a group of clients are travelling with one or more Living my Life providers to planned activities the supplier will provide the transportation vehicle and the supplier can invoice for provider time and kilometres apportioned across all the clients in the vehicle whether ACC funded clients or not. No additional payment will be made by ACC, nor will the client be required to make any additional contribution.

15.6. Calculating Travel Costs

The service item codes for travel are

LMLTT5 – Travel time for the first 60 minutes

LMLTT1 – Travel time – subsequent hours

LMLT6 – Other Travel

LMLTD10 – Travel distance

If the services are provided in a place other than the supplier's facility and the supplier needs to travel to the client, travel should be managed to maximise coverage and service time and minimise the distance travelled.

Territorial Authorities (TA)

ACC contracts for LmL services using territorial authorities (TA) to define areas of coverage.

When a supplier has applied and been approved for a specific TA area they are confirming they can deliver LmL within the individual TA area. ACC understands that due to resource restrictions a supplier cannot have a separate team in every TA they are contracted for. Therefore, travel between TAs is common. ACC has an expectation that suppliers will work hard to minimise travel costs and unproductive time.

Travel is invoiced on a trip by trip, provider by provider basis using the following method.

Scenario – Territorial Authority (TA)	
Where the provider's travel is within a single contracted TA.	Where the provider/supplier base is within the same TA as the client no prior approval is required. The supplier will invoice ACC for each trip the provider takes. Notify the recovery team member where the frequency of travel escalates costs.
Where the provider's travel is across multiple contracted TAs.	Where the provider/supplier base is in a different TA from the client, travel should be discussed with the recovery team member. If the recovery team member doesn't respond within two working days, the supplier can assume the travel between TAs is accepted. The supplier will invoice ACC for each trip the provider takes. Notify the recovery team member where the frequency of travel escalates costs.
Where the provider's travel is from outside of the supplier's contracted TAs to inside the contracted TAs.	Travel to and from the supplier's TA that is closest to the provider's location is at their own cost. Once within the supplier's TA the above scenario applies.

Maximise coverage

All attempts should be made to ensure that the supplier is fully occupied throughout the day of travel, therefore, multiple appointments should be made and the maximum number of clients scheduled.

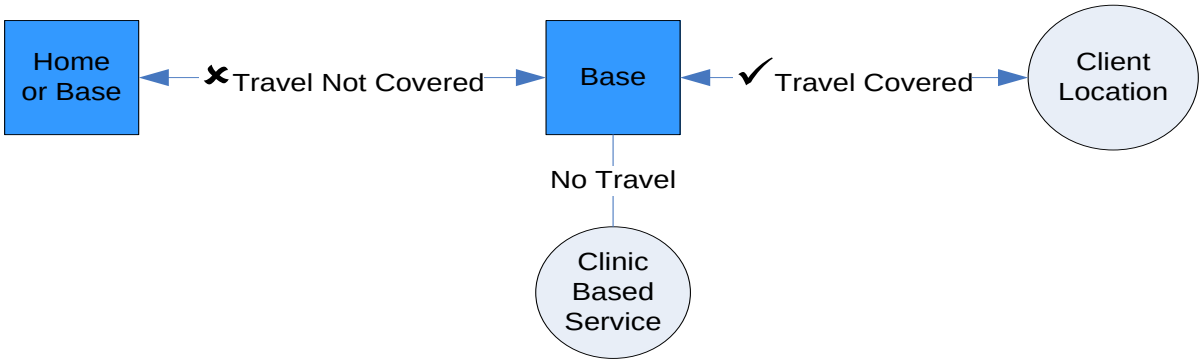
Service time

The service time will be appropriate to clinical need and best practice. If the time with the client is less than required the supplier should fill in the time up to the scheduled time with client-related activities such as updating client notes, phone calls etc.

Distance travelled

Appointments should be arranged to ensure the shortest distance between clients, thereby minimising the time and distance travelled. The supplier cannot claim travel time or distance

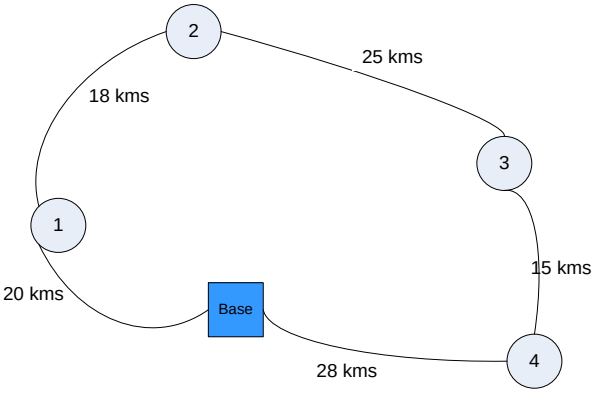
when a provider travels from one base of operation to another or from their private residence to the base of operation.



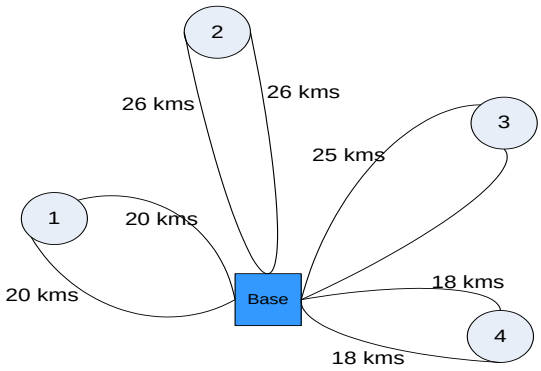
Travel distance LMLD10

Suppliers and their staff look to minimise travel costs wherever possible. Travel from a base of operation should be for services to a number of clients.

As represented in this loop ✓



rather than this star ✗



In the case of the loop the supplier would recognise a single incidence of 20km, whereas the star would recognise four incidences of 20km.

In many instances the clients seen may not all be ACC clients. Allocation of travel costs between the ACC and non-ACC clients should be done in a fair and reasonable way that is reflective of the true costs to the service purchasers/funders.

This example assumes one of the clients is not being funded by ACC.

Loop ✓	Total Travel (km)	Return Travel (km)	Tot. Incl Return Travel (km)	ACC Clients (km)	Less 20 km deduction	Invoiced
Client 1 – Other	20	7	27			
Client 2 – ACC	18	7	25	25	7	18
Client 3 – ACC	25	7	32	32	7	25
Client 4 – ACC	15	7	22	22	6	16

Return Travel	28		-			
Total km	**106**	**28**	**106**	**79**	**20**	**59**

Star	Total Travel (km)	Return Travel (km)	Total Travel	ACC Clients (km)	Less 20 km deduction	Invoiced to ACC
Client 1 – Other	20	20	40			
Client 2 – ACC	26	26	52	52	20	32
Client 3 – ACC	25	25	50	50	20	30
Client 4 – ACC	18	18	36	36	20	16
Total	**89**	**89**	**178**	**138**	**60**	**78**

Travel time LMLTT5

If it takes 15 minutes to travel the first 20km and the overall time spent travelling for the day is 140 minutes, then the supplier can invoice for 125 minutes of travel time if all the travel time relates to ACC clients.

Contract Travel Provisions

The following travel provisions relate to the contracted territorial authorities. There cannot be any travel outside of the contracted regions without prior approval of the recovery team member.

15.7. Case conferences

Case conferences are important for providing an integrated approach to supporting a client within their local community. They are beneficial in clarifying issues, addressing barriers, planning ongoing management and resolving conflict.

The case conference can be held by the supplier with ACC and other service providers and/or community organisations to discuss any specific issues and the client's programme, including their goals. The client and family/ whānau may be included.

After the case conference the supplier will send brief an update to ACC where ACC action is required. The update would briefly describe what the barriers are, the supplier's plan to mitigate or resolve those barriers and any ACC support required to achieve that.

15.8. Timeframes

The supplier should agree timeliness and communication expectations with the recovery team member when accepting the referral. The supplier will confirm those expectations to the recovery team member via email to ensure everyone is agreed.

Service Components	Activity	Timeframe
All service components	Notify ACC of the acceptance or decline of the Referral	Within 2 Business Days of receipt of referral

Service Components	Activity	Timeframe
Clause 4.3	*Note: Initial introductory referral for Tailored Supports*	
	Make contact with the Client	Within 1 Business Day of referral acceptance
	Notify ACC when the Client did not attend	Within 24 hours
	Resubmitted Reports with amendments	Within 2 Business Days of request by ACC
Facilitated Pathway Map Clause 5.7	Develop the Pathway Map with the Client	Within 3 months of accepting the referral
	Provide ACC a copy of the Client's Pathway Map	Within 5 Business Days of final session
Independent Facilitation Clause 5.7	Work with the Client and facilitate	Within 3 months of accepting the referral
	Provide to ACC the Independent Facilitation Summary Report	Within 10 Business Days of final Client session
Tailored Supports Clauses 5.8 – 5.17	Hold the introductory meeting with the Client, family/whānau and ACC	Within 5 Business Days of accepting the introductory referral
	ACC will send a referral confirming Provider selection	Within 2 Business Days of the Introductory Meeting being held
	When the supplier must decline the referral for Tailored Supports	Within 2 Business Days of the referral being received
	Submit to ACC the Client's Tailored Supports Plan	Within 10 Business Days from accepting referral
	Provide Tailored Supports to the Client over the planned period	Up to 12 months from the plan being approved
	Provide the Tailored Supports interim update report to ACC	At programme mid-point or at 6 months of the plan being approved (whichever is earliest)
	Provide the Tailored Supports service review report to ACC	Within 10 Business Days prior to the service review date or at the 12-month point (whichever is earliest)
Coaching to Self-manage Clause 5.18 – 5.22	Provide the Client with coaching to enable them to manage their support services	Within 3 months of accepting the referral
	Provide to ACC a written summary of the Clients preferred self-management menu option	Within 10 Business Days of last Client session

15.9. Extension of the Service Components

The supplier will contact the ACC's recovery team member as soon as it's clear that the client's support needs to be reviewed . The supplier should not wait until the end of the service period for the service review report as this may interrupt or delay the support the client receives and cause distress. After discussing the situation with the recovery team member, the supplier may be asked to provide more information and rationale to explain why services need to continue. The recovery team member may request that this be in the form of either a interim update report or a service review report, depending on the client's situation.

15.10. Interruptions to service delivery

Interruptions to delivery of the Service can occur periodically due to many factors such as illness, change in living arrangements, age and stage milestones. Given the long-term nature of Tailored Supports for some very high-needs clients these interruptions may be able to be anticipated but some can be due to a crisis or acute health issue. If an interruption is likely to be time bound it is reasonable that the supplier and ACC recovery team member consider the option of extending the period of the episode or if the interruption is likely to be indefinite the episode would need to be ended and re-started later.

15.11. Did not attend

Clients with a significant impairment or disability may require help to ensure they attend appointments such as:

- an appointment card
- a reminder letter
- a phone call or text message 24 hours prior
- family/whānau point of contact
- collection from their home to their appointment and return.

Where the client has not attended their scheduled appointment and not notified the supplier 24 hours prior, the supplier can request ACC to contribute to their costs. ACC will contribute within the following restrictions:

- No more than 3 missed appointments during the full length of the service (individual purchase order)
- ACC was notified by email within one business day of the missed appointment
- A maximum of 2 hours for each appointment missed
- Only a single provider can be invoiced for
- A contribution of:
    - 40% of the expected fee when the appointment was onsite
    - 60% of the expected fee when the appointment was offsite.

If the criteria are met ACC will confirm within with an update purchase order within two business days of receiving the form.

If the client repeatedly does not attend appointments this should be communicated to the recovery team member to consider if the client should exit Living my Life or alternative strategies implemented.

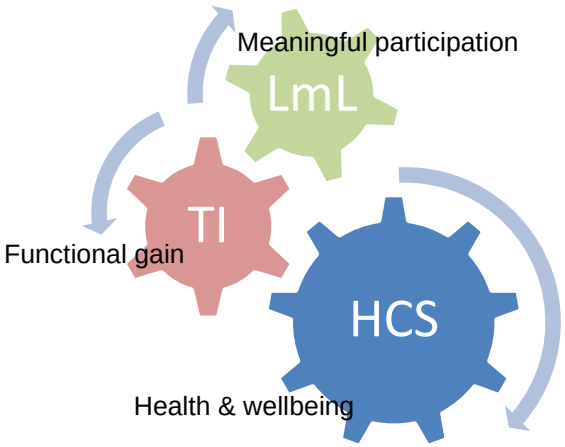
15.12. Working with other ACC and Non-ACC services

There are no specific exclusions, but every ACC service must be working toward client goals distinct to the nature of the service.

- The Training for Independence service is a rehabilitation service. For a client to participate they must be able to benefit (i.e. likely to achieve a functional gain)
- Living my Life is a disability support service. For a client to receive support they should need that support.

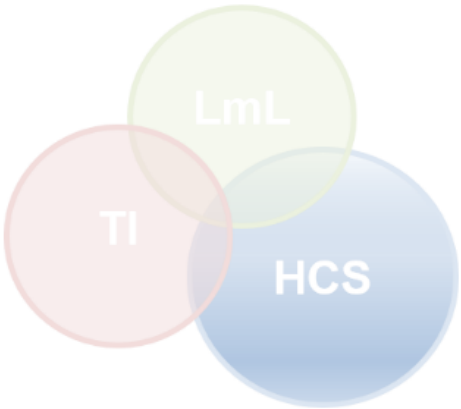
Mainly a Training for Independence rehabilitation programme is used to train the client to use an item of equipment or acquire a skill that cannot be learnt within this service.

Tailored Support includes any personal care and a referral for an episode would require an adjustment to Attendant Care Community access hours. The exception would be where a client has exceptional needs in which case consideration via a Support Needs Assessment would be indicated.



ACC is looking for service suppliers to work with the client within their own service's purpose and intent, so it is expected that the client's service needs, and goals would be different within each service.

ACC does not want overlapping and similar goals between multiple service providers as it is inefficient and often ineffective.



Different suppliers with the same or similar goals can leave the client unsure of what they should be doing.

<u>The inter relationship between services is described in the following table.</u>

Service	Description
Home and Community Support Services	HCSS includes the provision of flexible support services in the client's home and community including • attendant care • home help • childcare to achieve maximum level of participation in everyday life. Both services can be provided concurrently as client's move through recovery to living with a disability. Living my Life may be used to support transition from attendant care as clients adapt to the impacts of living with a disability and gradually move to use of natural community support. Coaching to Self-Manage includes consideration for how the client might choose to have support to manage their attendant care.
Support Needs Assessment	The Support Needs Assessment (SNA) and the Individual Rehabilitation Assessments are key assessments when considering appropriate the mix of the types of support required increasing independence and participation. The SNA Assessors describe the need for and recommend types of support to meet the client injury related need. Living my Life providers will not be required to undertake additional assessments as the tools used in the SNA provide suitable functional benchmarks.

Service	Description
Training for independence	Training for Independence Services focus on addressing the mediators of rehabilitation and Living my Life focuses on addressing the mediators of disability to maximise full participation. The intention is not to provide both Training for Independence and Living my Life concurrently as the rehabilitation outcomes achieved in a Training for Independence programme could subsequently inform the meaningful goal setting used in a Tailored Supports programme. There may be occasions where it is useful to have a Living my Life component i.e. Independent Facilitation concurrently in place to support the client understanding and engagement. Use of case conferencing to ensure effective communication between teams would be recommended to ensure alignment of goals and thereby reduce the possibility of over-servicing.
Vocational Rehabilitation Services	Vocational Rehabilitation services aims to return the client who were earners at the time of injury to their previous employment level or prepare the client for employment that matches their experience and training pre-injury. Vocational Rehabilitation includes targeted services and assessments. Living my Life aims to support clients with a significant impairment or disability, both earners and non-earners to achieve employment participation. Support is focussed on improving employment confidence, pre-employment and employment skills. Providers will facilitate access to internships, work experience, educational and employment opportunities and creation of employment options including social enterprises. There may be occasions where it is useful to have a Living my Life component i.e. Facilitated Pathway map occur concurrently to support the client investigate their aspirations to inform their Vocational Rehabilitation service. Where a Vocational Rehabilitation service is ending and it is identified that Tailored Supports would further support employment outcomes use of case conferencing to ensure effective communication between teams would be indicated.
Residential Support Service	Residential Support Services may be recommended for clients who are unable to live independently in the community, or for those who are temporarily unable to return to their own homes following discharge from hospital, due to safety concerns. Living my Life components can be used to support clients to look at short-term accommodation options or be supported to move to or return to living independently in the community, with people they choose to live with.
Hospital admission	A hospital admission could be planned or urgent for clients and may or may not be related to the client's injury, impairment or disability. Once a client enters hospital, community supports are placed on hold until the client is discharged and able to re-engage in

	these services. Recovery team members may need to advise Living my Life providers and others who are involved with the client of the hospital admission
Urgent Care	Urgent care maybe required due to deterioration in function, regular carers unable to provide support for the client. If the client receives their care from an agency/contracted provider, the agency will arrange for one of their staff to address the urgent care need. If the client receives their care from family members an emergency backup process has been agreed with the lead HCSS agencies who will ensure the client receives the support they require
Ministry of Health/Ministry of Education MSD Services Enabling Good Lives	ACC clients may be eligible for supports from other government funders, it is important to discuss with ACC what other supports the client maybe or could be receiving.

15.13. Support from ACC

ACC has provided specific people to help manage this contract. You will be assigned an Engagement and Performance manager who will:

- Support your relationship with ACC recovery team members and Branches
- Provide feedback on your performance.

15.14. Electronic Invoicing

All suppliers are required under the ACC Standard Terms and Conditions clause 10.2(e) to electronically file their invoices.

There are 3 electronic invoicing solutions and the last 2 are free.

1. A suitable Practice Management System that the supplier chooses which can generate electronic invoices to ACC.
2. An electronic invoice form (ACC47e) on the eBusiness Gateway, where suppliers can submit single client invoices as they are ready to invoice.
3. An ACC digital application that takes invoicing data entered into a prescribed CSV file (spreadsheet). This is suitable for bulk invoicing.

   Here is a simple user guide that shows you how easy it is to download, install and use SendInvoice. Please look this over as you consider your options. You can also view our 'how-to' videos in ACC's Youtube channel that will show the process in a simple step by step format.

More information can be found on https://www.acc.co.nz/for-providers/set-up-online/#getting-set-up-using-a-practice-management-system.

For services that do not require providers to be named on the contract or invoices, there is a 'dummy id' can be used and its J99966. ('Provider id' is currently a mandatory field in ACC eBusiness Gateway)

If you are not electronically invoicing please follow this link to aww.acc.co.nz. Getting set up online

For electronic billing enquiries, contact the eBusiness team:
Phone 0800 222 994 (option 1)
Email ebusinessinfo@acc.co.nz

16. Glossary

This list is in addition to those outlined in the service specification.

BAP	ACC Branch Advisor Psychologist
BMA	ACC Branch Medical Advisor
BM	ACC Branch Manager
Recovery team member	The ACC staff responsible for co-ordinating the client's treatment and rehabilitation. These people can have different names and slightly different roles depending on the responsibilities of the unit they are working in.
EPM	Engagement and performance management.
Incapacity	Relates specifically to the client's pre-injury occupation and their ability to perform their pre-injury employment and hours worked. If a client is found to have incapacity, they are no longer able to engage in their pre-injury employment
Limitations	What the client is unable to do or existing constraints on their physical or mental capacity to perform required tasks. The assessment of limitations needs to be based on objective findings considering physical, cognitive, social interaction, endurance and tolerance factors where relevant.
Non-injury related factors	Disabilities or health conditions that do not relate to the injury either directly or as a consequence of an injury. Injury and non-injury factors should be clearly differentiated in any reports. This is essential to ensure that all treatment provided is targeted towards treatment and rehabilitation of the covered injury.
Supplier	The contract holder
Provider	The person delivering services to the client
TLA/ TA	Territorial Local Authority and Territorial Authority refers to areas within a region.